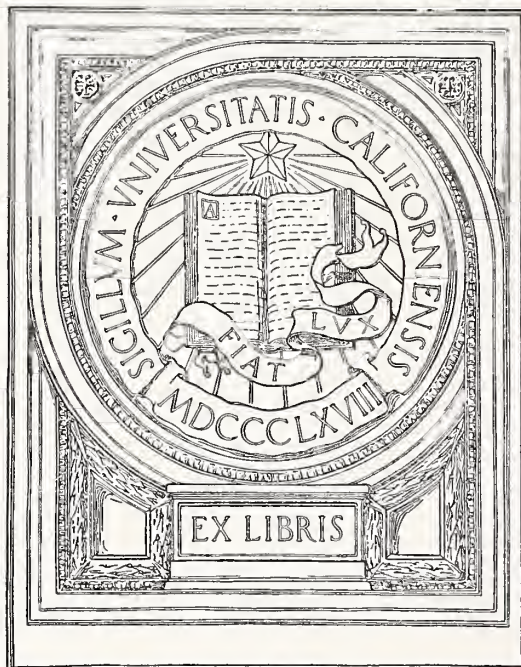


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JOURNAL of The Medical Association of Georgia

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DAVID HENRY POER, M.D., EDITOR

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January-December, 1953

MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree, N. E., Atlanta



JOURNAL of The Medical Association of Georgia

JANUARY • 1953

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The JOURNAL

of the

MEDICAL

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OF GEORGIA

JANUARY, 1953

VOLUME 42 NUMBER 1

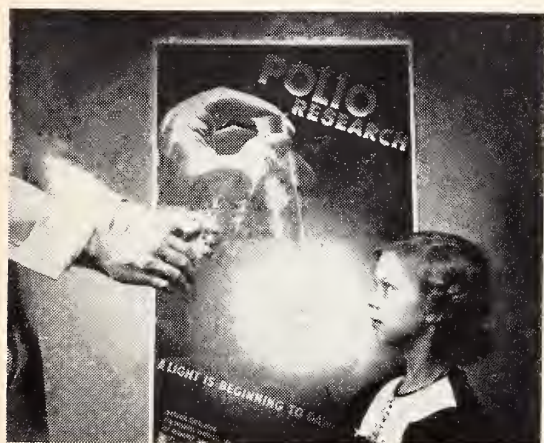


Photo by Ted F. Leigh, M.D.

To inaugurate the newly designed cover of the JMAG, research in poliomyelitis has been set as the theme for January. Dr. William Friedewald's editorial on Gamma Globulin and Fred Mitchell Bell's article on "Problems in Weight Bearing and Gait in Poliomyelitis" highlight the January polio month motif.

Expert photographer Dr. Ted F. Leigh is responsible for the artistic representation of research in polio on the cover page.

Next month the February issue of the JMAG is slated to be a specialty number devoted to the "Heart" and with the cooperation of the Georgia Heart Association all the scientific articles will deal with subjects concerning the heart.

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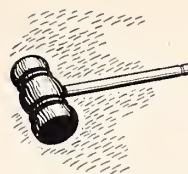
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President's Page



DR. C. F. HOLTON
MAG President

For

Whom

The

Shoe

Fitteth

AN ODE TO ELIZABETH

These here verses to
An ancient but charming gal
Are from her equally aged
And decrepit pal.

When in the cold grey dawn
Your eyes are baggy
And all your chins are
Completely saggy
You're sixty.

When in the evening
You are invited to play
And you had definitely
Rather hit the hay
You're sixty.

When you are coiled up
In your favorite nook
And ALL you want
Is a sexy book
You're sixty.

When you know that
Grandchildren on your knee
Is not as much fun
As starting a familee
You're sixty.

When, at night
You shed your dresses
And shy away from
Masculine caresses
You're sixty.

When you tell a story
Be it dull or full of wit
And to the same listeners
Often re-tell it
You're sixty

They say age has its pleasures
But though I've searched near and far
I'll be darned if I know
What they are
I'm sixty.

C. F. HOLTON, M.D.

The JOURNAL of the Medical Association of Georgia

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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MEDICAL EDITING SERVICE. If in the opinion of The *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach The *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

REMEMBER THE DAY — THE 10-13TH OF MAY

Medical Association of Georgia District and County Officers

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10th District—A. W. Simpson, President, Washington; J. B. Traylor, Secretary, Athens. Second Wednesday—February and August.
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Conference Headquarters — Municipal Auditorium
MARCH 2-5, 1953

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Gastroenterology
Herbert E. Schmitz, M. D., Chicago, Ill.
Gynecology
Carl V. Moore, M. D., St. Louis, Mo.
Hematology
Rudolph H. Kampmeier, M. D., Nashville, Tenn.
Internal Medicine
Henry A. Schroeder, M. D., St. Louis, Mo.
Internal Medicine
Guy L. Odom, M. D., Durham, N. C.
Neurosurgery
Andrew A. Marchetti, M. D., Washington, D. C.
Obstetrics
Harold F. Falls, M. D., Ann Arbor, Mich.
Ophthalmology

J. Vernon Luck, M. D., Los Angeles, Calif.
Orthopedic Surgery
G. Edward Tremble, M. D., Montreal, Canada
Otolaryngology
Arthur P. Stout, M. D., New York, N. Y.
Pathology
Waldo E. Nelson, M. D., Philadelphia, Pa.
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Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

G. P. Page



J. P. SANDERS, M.D., Shreveport, La.

The Influence of the American Academy of **GENERAL PRACTITIONERS**

on American Medicine

The Academy was formed at the Claridge Hotel in Atlantic City, June 10, 1947, during the centennial meeting of the American Medical Association. There were 108 members present that night, and before the AMA meeting was over, there were 219 paid-up members.

It was generally agreed among the officers and board of directors of the new organization that state and local chapters would probably be desirable. As a consequence, members went back to their respective homes and began such procedures. There was no written material available; a few mimeographed constitution and by-laws were scattered over the country, and it was necessary to develop literature and other materials in each region. The Louisiana Academy was formed five weeks after the national organization was brought into being. The first six states organized were Southern states. This was due largely to the efforts of men with enthusiasm who had attended our original meeting in Atlantic City.

As soon as the state chapters were organized, they immediately began the organization of county and city chapters. For example, Louisiana organized on a congressional district basis, with eight chapters, while states like Missouri organized chapters in St.

Louis and Kansas City, and smaller units on the county or several-county plan.

It would be inadvisable to close this introduction without reference to the original board of directors. For example: Paul A. Davis of Akron, Ohio as President; E. C. Texter of Detroit, Vice President (second President); Stanley R. Truman, Secretary, (third President); and U. R. Bryner, Treasurer, (sixth President); these were all officers of vision and influence in the Academy. The nine members of the board of directors were outstanding in their own particular territory. G. Marchmont Robinson of Illinois, Benn of Minnesota, (both deceased) were "wheelhorses" in the early stages of our development. And there were other men—R. C. McIlvain of St. Louis, Dave Miller of Kentucky, H. T. Jackson of Texas (now Treasurer), Lester D. Bibler of Indianapolis (now Vice President), Arch Walls of Detroit, Lemmon of Akron, Ohio, and your speaker, all of whom had unusual vision, foresight, and a burning desire for the future of the Academy.

IDEALS OF THE ACADEMY

The ideals of the Academy were set forth largely in the original constitution and by-laws. This constitution and by-laws was gotten up through the efforts of Drs. Texter and Truman, and the general practitioners of America were circularized before the Atlantic City meeting through the efforts of these two men. The over-all picture and chief ideal of the new Academy was to produce better general practitioners. In order to accomplish this, certain standards had to be set, to make sure that they were better general practitioners. Their interests must be largely in general practice. They must be willing to do 150 hours of post-graduate work every three years in order to stay in the organization. This was a new

Read before the Georgia Chapter, AAGP, at Macon, October 23, 1952.

concept among specialist organizations. Others had made certain basic requirements to get in, but had gone to no effort in keeping these qualifications high to maintain membership. Obviously, the new Academy wanted to increase the prestige of general practitioners everywhere. There were some sidelights so far as increased income, increased respect in the community, and general better medical care for the patient which were sought after by the Academy set-up.

DEVELOPMENTAL STATE OF THE ACADEMY

It was found early in our organizational experience that Dr. Truman was giving entirely too much time to Academy work. He kept two secretaries busy, spent two afternoons and nights in correspondence, and almost lost his practice in carrying on this work. Over the country others were attempting to do some of the promotional work in their particular regions. It became evident, therefore, that a full-time secretary would have to be hired and central headquarters set up. Efforts were made to contact available men all over the country. Finally Mr. Mac Cahal, Executive Secretary of the College of Radiology, was hired to develop a headquarters office and staff. Without doubt, Mr. Cahal was the most capable man in the business. He developed a local staff in Chicago, and about a year later transferred this headquarters to the Porter Building in Kansas City.

Other projects had to be developed. Committees, commissions and other groups had to be formed and developed. Capable chairmen were picked out for these laborious jobs, and quickly put to work. For example, the hospital situation was terrible in most parts of the country. Under the able leadership of John O. Boyd of Roanoke, Va., and his commission, a hospital manual was published setting up the procedure for a general practice section in hospitals. This was a terrific task. It involved the cooperation of the American College of Surgeons, the American College of Physicians, the American Medical Association, and many other groups interested in hospital standardization. They did a magnificent job, and created practically no conflicts in doing it.

The Education Commission, under the capable leadership of Lester D. Bibler, and later Merrill Shaw, developed certain educational programs in the different states where general practitioners could get post-graduate training. These courses were accredited and supervised. This was a monumental task within itself. At all times there was the finest cooperation from the headquarters staff.

The Academy had to be integrated with other medical organizations. Conferences were held. Academy members spoke before other groups, such as the American Hospital Association, outlining our aims and ideals. Finally, the AAGP was accepted as the spokesman for the general practitioners of America. This was no easy task. Many conflicts presented themselves, which had to be ironed out. Many times it was found necessary to sit down across the conference tables, swap our ideas with the members from other groups who might be suspicious, and show to

them that the desire was real in that the Academy did not want to take over the show, but wanted to be a part of it.

Scientific assemblies were developed on a national level, as well as state and local levels. Here again the organization attempted to get the best teachers possible, and put on something new in medical programs. Its success was rather unique. They were well attended; the audiences cooperative and attentive. All in all, they were successful.

THE JOURNAL "GP"

Early in the Academy's existence it was realized that a mouthpiece for the organization had to be developed. At times some members thought it best to select some journal already in existence. Many journals turned to the Academy for endorsement. All in all, it seemed impossible to find a journal exactly to our liking. We wanted something different in medical journalism—not just another journal. Too many of that type were already in existence. Too much "stuff" was already being printed. Finally it was decided to publish one of our own, and after many conferences and all sorts of inquiries, the name "GP" was selected. The first editor, Dr. Albrecht, was killed in an accident before the first issue came off the press. Fortune smiled on us, and Dr. Walter C. Alvarez, a great name in medicine, accepted the post of editor.

In "GP" we have tried to present many departments which would be interesting to doctors. The scientific papers were short, accurate, and written for busy general practitioners. History and biography were left out. Tips from other journals, questions and answers, activities of the Academy, both national and state, and after hours, were all presented in this new book. Cartoons were interspersed to make it more readable. It was circularized to all our members, to medical schools, and to most of the hospitals over the country. Two surveys have been made to see how it is doing. Some departments were not read very much. The President's Page, carried only during the year of my presidency, was not too impressive. The doings of the Academy were also not very important. But it was found that internes and residents in hospitals, and many other doctors over the country read "GP" before any other journal. In some places, "Medical Economics" was read first.

Obviously, "GP" advertisers were soon aware of this fine medium for displaying their products. It is hardly worthwhile to say that "GP" is paying its load financially.

OUR FRIENDS

Little opposition has arisen against us from any quarter. The specialists have arisen to our cause from the start. They had realized already that specialization had gone too far. They have been glad to offer their services as teachers whenever they were called upon, both as individuals and as organizations. The medical schools and the teaching hospitals were quick to get on our bandwagon. We find that the medical schools are putting more and more general

practitioners on their teaching staffs. The hospitals are including residencies in general practice and general practice sections in their professional set-ups.

The commercial concerns themselves have been our friends from the start. No one can say that Wyeth has not gone all out to help the general practitioners. The M & R Laboratories were the first to offer awards for the best scientific articles published each year in "GP" by our members. Mead-Johnson has set up a scholarship fund of \$5,000.00 per year to deserving young internes to go into general practice residences. Practically every other commercial house in the country is either showing on our national programs or our state programs, or both. Practically all are advertising in our Journal.

And patients realize as never before the value of the family doctor. Every day we have someone come in asking for a family physician. They have an increasing respect for us. They are helping us broaden our field. In the patients' minds, we are taking our rightful place in present medicine. We are constantly increasing our overall care for all the patients' needs.

THE PRESENT STATUS OF THE ACADEMY

We are reaching maturity in our Academy, probably never seen before in any new medical organization. We have 50 state chapters, covering every state, the District of Columbia, and Hawaii, with many more local chapters. We have a membership of over 15,000, and a prestige which has not existed

before in this century. We are rapidly becoming the best trained men in medicine, and should offer no apology to our patients, to our teachers, or to our specialist friends for being general practitioners. We are putting on fine programs, are getting more and more training constantly, and have developed one of the finest journals on the market. We are doing good medicine, carrying on good business and professional relations, and are economically sound. We can rightfully now be called the "Backbone" of medicine.

OUR FUTURE

In the future, the AAGP can expect to grow and to mature. We expect the general practitioners to take their rightful place in medical organizations on every level. We are sure that there will be an increased utilization by the general practitioner of the hospitals and their facilities. If we are to assume the overall care of our patients, then we must stay on the case until it is properly terminated.

Medical schools will have increased numbers of general practitioners on their teaching staffs. While research will still be carried on by specialists, medical schools, and pharmacal houses, there is a certain amount that must inevitably come from the general practitioners. Certainly, we will see an increased amount of writings from general practitioners in medical journals and textbooks. There will be an ever increasing number of general practitioners taking post-graduate courses until finally we will be the best trained men in medicine.

REMEMBER THE DAY

THE 10-13 OF MAY

Medical Association of Georgia

103rd Annual Session at Savannah

On The Bulletin Board



Information Bulletin Volume IV, No. 7.

Item I: Entry into service of the balance of Priority I and Priority II physicians.

The Selective Service System and the Department of Defense have undertaken several programs for completing the call up of physicians in Priority I and Priority II insofar as possible, before starting the call for Priority III physicians. These actions include:

- (1) Re-examination of certain physically disqualified physicians of Priority I and Priority II to determine whether or not they can be qualified by virtue of the Armed Forces waiving certain conditions so that most of those physicians who carry on active professional careers in civilian life can be commissioned.
- (2) Review of the essentiality of special registrants deferred or Reserve officers delayed who are in Priority I and Priority II to de-

termine the present status of their essentiality to the national health, safety or interest or, conversely, their availability for military service.

MEDICAL OFFICERS RELEASED FROM SERVICE

Dr. Talmadge McK. Martin, Jr., 333 Heard St., Elberton, Ga. (3380th Med. Grp., Keesler AFB, Miss.—Release: 1/14/53)
Dr. Lewis A. Munro, 1301 Rigdon Rd., Columbus, Ga. (3700th Med. Grp., Lackland AFB, Texas—Release: 1/14/53)
Dr. Waddell Barnes, 3245 Vista Circle, Macon, Ga. (Release 1/25/53)
Dr. James H. Brown, R.F.D. No. 1, Rossville, Ga. (From Naval Hospital, Yokosuka, Japan (Release: 1/15/53)
Dr. Clyde A. Burgamy, 1716 Holly Hill Road, August, Ga. (Release: 1/15/53)
Dr. Thomas N. Guffin, Rte. 4, Box 225-G, Atlanta, Ga. (Release: 1/15/53)

In the Editor's Mail



American Medical Education Foundation
535 N. Dearborn St., Chicago 10, Ill.
August 14, 1952

Medical Association of Georgia
875 W. Peachtree St., N. E.
Atlanta, Georgia
Gentlemen:

Please accept my apologies for the delay in acknowledging the fine gift of \$10,000 from the Medical Association of Georgia.

The Association is to be highly commended for its forthright action in this action on behalf of Medical Education.

The officers and directors of the American Medical Education Foundation extends their sincere thanks to your organization for its splendid support of the Foundation program.

Cordially,

HIRAM W. JONES

The American Cancer Society, Inc.
Georgia Division, Inc.
205 Red Rock Bldg., 187 Spring St., N. W.
Atlanta, Ga.

To the Editor:

I have just read the article "And Yet They Practice" in the November *Journal* and, as a layman, I want to express whole hearted approval.

We have been holding Area Leadership Conferences over the state. These have been attended by

volunteer lay workers interested in the educational part of the Cancer program. In two meetings we have had the problem of the 'quack' brought before us and there seems to be so very little that we can say in answer to the problem. I have a letter on my desk today about a 'quack' in the state who has a cure for cancer. We heard about him and it seems that he is doing a 'landslide' business. The only answer we can give is to keep pounding in a media that there are only three known cures for cancer . . . x-ray, radium, and surgery.

If the American Cancer Society, Georgia Division can do anything to help with this problem I know that you can count on Dr. Calloway and Dr. Scarborough and our other officers.

Sincerely,

LON SULLIVAN

Dr. Charles Eberhart
704 Piedmont Ave., N. E.
Atlanta, Georgia
December 4, 1952

To the Editor:

I want to commend you and personally thank you for the marked improvement in our *State Medical Journal*. My compliments and appreciation is also extended to your staff.

Sincerely,

CHARLES EBERHART, M.D.

(Comments of this kind warm our hearts.—Editor.)

THE JOURNAL

of the MEDICAL ASSOCIATION OF GEORGIA

VOLUME 42

JANUARY, 1953

NUMBER 1

Editorials

POLIOMYELITIS, *Pathogenesis and*

Prophylaxis with Use of

GAMMA GLOBULIN

Preliminary reports indicate that Red Cross gamma globulin provides significant protection against paralytic poliomyelitis. These experiments provide the first definitive evidence that passively transferred antibody can alter the course of the disease in human beings. It should be recognized that a vast amount of work in experimental animals preceded and made possible the human experiment. Major developments in poliomyelitis research in recent years include (1) the recognition of three distinct immunologic types of virus, (2) the importance of viremia in the pathogenesis of the disease, (3) the growth of poliomyelitis virus in tissue culture and (4) the protective effect of antibodies in experimental animals, whether passively transferred or induced by vaccines. These findings and many others based on the work of numerous investigators have led to an altered concept of the pathogenesis of poliomyelitis.

There is almost complete agreement that the virus of poliomyelitis usually is spread by person-to-person contact, and that it enters the body by way of the mouth. Primary multiplication of the virus occurs in the alimentary tract in paralytic as well as in silent

infections. The virus then apparently gains entrance into the blood stream and penetrates the central nervous system, where secondary multiplication of virus occurs. Viremia has been observed in chimpanzees after simple virus feeding as early as five days before the onset of paralysis. The failure to demonstrate virus in the blood stream of human beings has been attributed to the high levels of serum antibody, which is already present at the time of onset of paralysis. According to the present concept, therefore, viremia is a necessary precursor to infection of the central nervous system. The experimental evidence thus far indicates that serum antibody can interpose a barrier to the passage of virus from the alimentary tract to the central nervous system, thus preventing the paralytic disease, but not altering the alimentary phase of viral multiplication.

The demonstration of the usefulness of gamma globulin in poliomyelitis poses serious problems for the physician at this time. It is clear from the preliminary reports that gamma globulin is not completely effective in preventing the paralytic disease and that its effect is transitory, since passively transferred antibodies are rapidly removed from the body.

More serious is the shortage of gamma globulin supplies. It has been estimated that 500 cc. of blood is required to produce one average dose (7 cc.) of gamma globulin. Furthermore, gamma globulin is needed under certain conditions for the prevention of measles and infectious hepatitis. Obviously the

widespread use of gamma globulin for the prevention of poliomyelitis is not practical and allocation of the available supplies will be restricted necessarily to epidemic areas. It is hoped that an effective vaccine will soon be forthcoming.

WILLIAM FRIEDEWALD, M.D.

The Georgia POSTMORTEM

EXAMINATION *Act*

One of the serious needs of our complex society is the assistance of physicians in solving deaths occurring under suspicious circumstances. A few of the larger communities in Georgia now regularly employ Coroner's Physicians, but most of our state is inadequately covered in this respect. We simply do not have a mechanism set up to take care of the situation.

A new law has been proposed, entitled "The Georgia Postmortem Examination Act." This bill is sponsored by Representative B. C. Gardner of Dougherty County. Mr. Gardner and others have spent a great deal of time studying the situation, examining the experience of other states and also considering the means that we have available in Georgia to improve the situation. According to the bill as planned, Coroners all over the state will have Medical Examiners available to perform autopsies on all cases where legally indicated. It is planned to solicit and engage physicians from all parts of the state to be assigned to appropriate territories for this purpose. The appointments will be made jointly by the Directors of the State Department of Public Health and the State Crime Laboratory. The physicians used will be those who are particularly competent for such work, and the bill provides adequate remuneration for service.

In case a physician is not available, at any time for any particular autopsy, the autopsy will then be performed by a member of the State Crime Laboratory. The Crime Laboratory Pathological material will be sent to the State Crime Laboratory for any studies by pathologists, chemists or others that may be required. Reports will be permanently filed in the State Crime Laboratory for public use whenever needed.

Of particular interest to all physicians is a provision definitely stating who may grant authority for autopsies, and under what conditions such authority may be granted. This provision is modeled after the Wisconsin law adopted in 1950. The Wisconsin law has been favorably regarded and is perhaps the best so far adopted by any state. Several other states are now considering its adoption.

This bill will be introduced early in the coming session of the state legislature. Copies of the proposed measure have been prepared for inspection and may be obtained by writing Mr. B. C. Gardner in care of the State Legislature. It appears that the measure is a strong, forward step urgently needed. Georgia physicians are requested to acquaint themselves with this measure and to suggest any changes or improvements desired.

WARREN B. MATHEWS, M.D.

Proposed "INJUNCTION LAW"

Recent editorials in the *Journal* have emphasized the need in the State of Georgia for an "injunction law" to prohibit unqualified persons from engaging in the practice of medicine. The Medical Association of Georgia has instructed its Committee on Legislation to explore and recommend ways to strengthen and improve the Healing

Arts law. And in conjunction with the State Medical Examining Board, the Association is supporting a Bill which will be submitted to the legislature for action in this area. This Bill will serve to answer a real problem of the profession; the problem posed by the fakes, the quacks—the men without scruples who degrade the healing arts and threaten the public

welfare by engaging in the practice of medicine without the necessary qualifications.

This bill is printed herein as it will be presented to the legislature. It should have your wholehearted endorsement.

A BILL

To be entitled an Act to amend an Act which abolished State Examining Boards included in Title 84 of the Georgia Code of 1933 and those created by certain other Acts, and which created in lieu thereof new State Examining Boards and Commissions, approved March 20, 1943 (Ga. Laws 1943, p. 212); to grant to the new State Examining Boards and Commissions the power to enjoin any person from engaging in or practicing in any of the businesses, professions or trades regulated by said Act without being registered or licensed by the respective Examining Boards and Commissions; to make said activities a menace and a nuisance dangerous to the public; to repeal conflicting laws; and for other purposes.

Be it enacted by the General Assembly of Georgia as follows:

Section 1. An Act which abolished State Examining Boards included in Title 84 of the Georgia Code of 1933 and those created by certain other Acts, and which created in lieu thereof new State Examining Boards and Commissions, approved

March 20, 1943 (Ga. Laws 1943, p. 212), is hereby amended by adding a new section, which shall be known as Section 3(a), which shall read as follows:

"3(a). All Examining Boards and Commissions herein created may bring an equitable proceeding to enjoin by a writ of injunction any person who without being licensed or registered to do so by said Examining Boards and Commission engages in or practices in any of the businesses, professions, or trades herein regulated. The proceeding shall be filed in the county in which such person resides, and unless it shall be made to appear that such a person so engaging or practicing is licensed or registered, the writ of injunction shall be issued and such person perpetually enjoined from said activities throughout the State. It shall not be necessary in order to obtain the equitable relief herein granted for the Examining Boards and Commissions to allege or prove that there is no adequate remedy at law. It is hereby declared to be a menace and a nuisance dangerous to the public health, safety and welfare to engage in or practice in any of the businesses, professions or trades herein regulated without being licensed or registered by said Examining Boards and Commissions."

Section 2. All laws and parts of laws in conflict with this Act are hereby repealed.

Continuous ACTH THERAPY
with GLOMERULONEPHRITIS
of Chronic NEPHROTIC EDEMA

Six patients with chronic glomerulonephritis and nephrotic edema have been treated for two to eight months with a new continuous method of ACTH GEL administration. All except one had had three to 10 ten-day intermittent courses of treatment followed by continued albuminuria and relapse into the edematous state. Duration of disease varied from one to 20 months. Two had beginning nitrogen retention and all had considerable albuminuria and edema. Ages were from nine months to four years. With some initial variations each was given an appropriate dose once daily until either free of albuminuria and hematuria or until a steady state of mild albuminuria was achieved. Then they

were abruptly changed to ACTH GEL every other day and the dose reduced gradually. All have been free of edema since institution of this schedule, whereas, they had fluctuated between edematous and dehydrated states with intermittent courses. Five have been without albuminuria for significant periods except for occasional relapses accompanying colds or too rapid reduction of dose. These relapses were abolished promptly by temporarily increasing the dose. The sixth patient is clinically well but has a very faint trace of albuminuria. All have been normally active after a brief initial period. Details and problems of this regime will be given.

ARTHUR J. MERRILL, M.D.

Problems in

WEIGHT BEARING *and* GAIT in POLIOMYELITIS

FRED MITCHELL BELL, Atlanta

In poliomyelitis the evaluation and treatment of the patient necessitate knowledge of fundamental muscle groups and actions. Those pertaining to gait and weight bearing problems briefly are as follows.

In the shoulder and arm, of main concern are the shoulder depressors and triceps. The triceps muscle is often the key to a patient's independence in ambulation. With triceps a patient may walk with crutches, but without this muscle a specially built crutch is necessary to hold the arm in extension.

The spine is very important in poliomyelitis. The spinal muscle groups and abdominals are frequently in contracture and/or in imbalance. The abdominal muscles normally hold the viscera in place, which is vital in weight bearing.

In the hip, movements pertinent to polio are: flexion mainly by the ilio-psoas; extension by the gluteus maximus; abduction by the gluteus medius; elevation by the "hip hikers", the quadratus lumborum and the latissimus dorsi.

This paper prepared by Mr. Bell while on a National Foundation for Infantile Paralysis Fellowship at the Georgia Warm Springs Foundation. Mr. Bell is a fourth year medical student at the Medical College of Georgia.

The knee has two main movements: extension by the quadriceps femoris, flexion by the hamstring muscle (biceps femoris, semitendinosus and membranosus).

Dorsiflexion of the foot to clear it in walking is accomplished by the anterior tibial and toe extensors. Plantar flexion and pushing propulsion against the ground are mainly accomplished by the soleus and gastrocnemius. The foot is the point of contact between the standing man and the ground. As such, it is the lower end point of force on the weight bearing axis.

CLINICAL EVALUATION AND TREATMENT

Poliomyelitis is no respecter of pattern in its destruction of musculature of the body. There may be mass groups involved or single muscles in a spotty manner.

The shoulder girdle is one section of body commonly involved. The levator scapulae and upper

trapezius may be destroyed, producing a dropped shoulder on the respective side. The shoulder and arm may be flail, and the arm simply dangle from the shoulder joint. This is in contrast to the normal gait, in which the arms swing fore and aft (15 to 20 degrees normally). If the serratus anterior is gone, the scapula will be noticed to push backwards, giving the "winged" appearance of the shoulder blade.

The thorax and abdomen and back may be involved. When looking at a poliomyelitis patient this region is often not as obvious as perhaps a braced leg or a flail shoulder or arm. The prognosis for life expectancy, however, is more closely tied up in this portion of the body. Therefore, the gait and weight bearing problems must be scrutinized and early deviation from normal detected. The deformity may occur early or not appear until five years or so after the onset of disease. Poliomyelitis may result in severe scoliosis of the spine. This lateral rotatory deformity may be high in the thoracic region, low in the lumbar area or in between. The scoliosis may be "C" type, long "S" shaped, or any combination of shape at the different spine levels. Depending on the specific combination, the body weight is abnormally distributed to the vertebrae and on the pelvis. Scoliosis in the upper spine often compresses one side of the lungs and enlarges the opposite side of the chest cavity. This predisposes to lung pathology, (i.e. pneumonia, atelectasis, emphysema, etc.). Rotation of the spine often occurs concomitantly with the scoliosis. This thrusts one side of the body forward and the other side backward. In the thorax, therefore, a rotation to the right will rotate the rib cage clockwise. This gives a bulging posteriorly of the patient's right chest and a pushing forward of the left. This deformity of chest wall predisposes to lung pathology of the type mentioned above. This de-

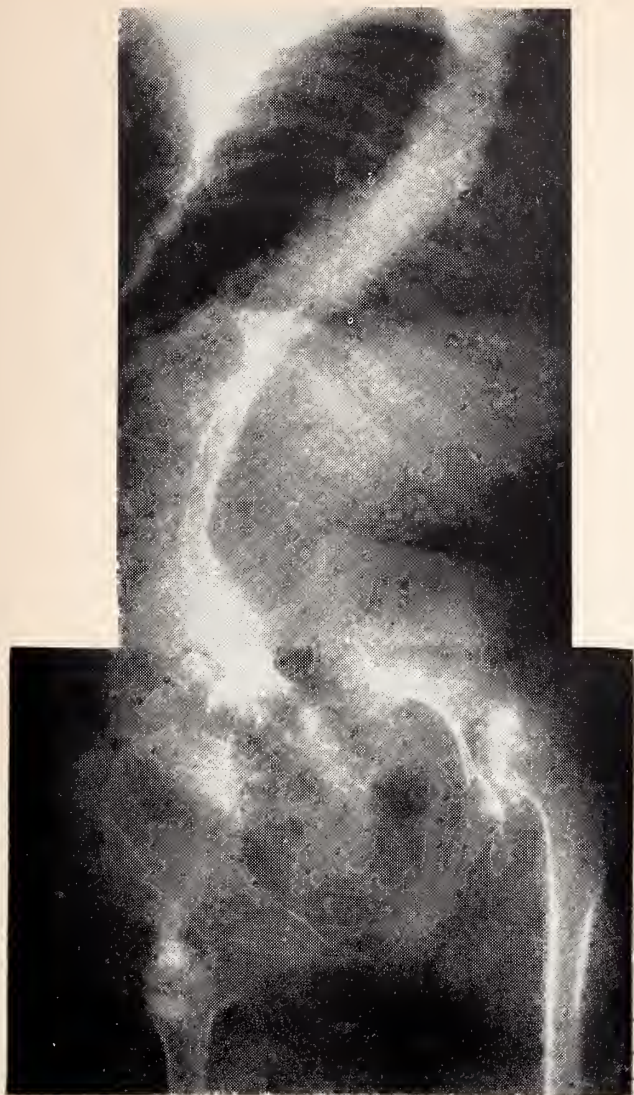


Figure 1. Severe scoliosis and pelvic deformity due to poliomyelitis.

formity is especially evident on forward bending. Prominence of one side of the back in this position, therefore, indicates abnormality of the spine. The gait may be relatively normal in scoliosis since in the long "S" type, the spine may curve in the lower part of the "S" and bring the weight axis to approximately a normal position over the pelvis. In such a case the pelvis would not be tilted. Such a spine would not be deforming to normal gait. Usually, however, the pelvis is tilted to one side, producing further deformities of weight bearing and of gait. In a "C" type curve the line of weight bearing is off-center over the pelvis and the individual will swing to the opposite side to compensate. This will shift the weight of the trunk over the pelvis higher, consequently. The one extremity is higher than the other and the patient walks with a short leg limp.

The tilted pelvis of poliomyelitis may be an integral part of the curved spine. It may, however, be free from the deformed spine and pulled into an abnormal position by muscle imbalance and

contractures not acting on the spine. The pelvic tilt may be produced by imbalance of muscles, contractures above the iliac crests, by contractures below, i.e. contracture of the iliotibial band, or a combination of these. If the pelvic tilt is slight, the limp may not be evident. This is possible because of compensatory mechanisms made by the patient: a slight flexion of the opposite knee; rising up on toes on the shortened side; a lateral curvature of the spine; or a combination of these.

Weakness in abdominal musculature can be helped by a proper fitting corset. This will generally improve the gait. Deep breathing, postural exercises, supports and sometimes spine fusion are necessary for scoliosis.

The legs are often involved in polio. The extensors of the leg (quadriceps femoris primarily) may be effected. Without this muscle group the knee is not stable in the extended position. If weight is put on the leg, it will buckle and the patient fall. Simple weakness here can be off-set with crutches or the use of a cane on the opposite side of the body. A good gluteus maximus can often compensate for the loss of quadriceps femoris.



Figure 2. Flexion contracture of hip. This demonstrates method of testing for contracture of hip. Any further extension of this patient's hip will throw the pelvis forward with an accompanying lordosis of the back.

Deformities from contracture of the iliotibial band are common in polio. The hip deformity is flexion-abduction. At the knee there may be a flexion contracture since the shortened iliotibial band inserts below the knee and posterior to the joint. Release of the iliotibial band contracture by the Ober and Yount type fasciotomy will enable the patient to get the lower extremity under him in a weight bearing position. Other deformities associated with a tight iliotibial band are lumbar scoliosis or lordosis, with tibial torsion, knee valgus and foot varus. When external rotation of the tibia occurs, the ankle joint

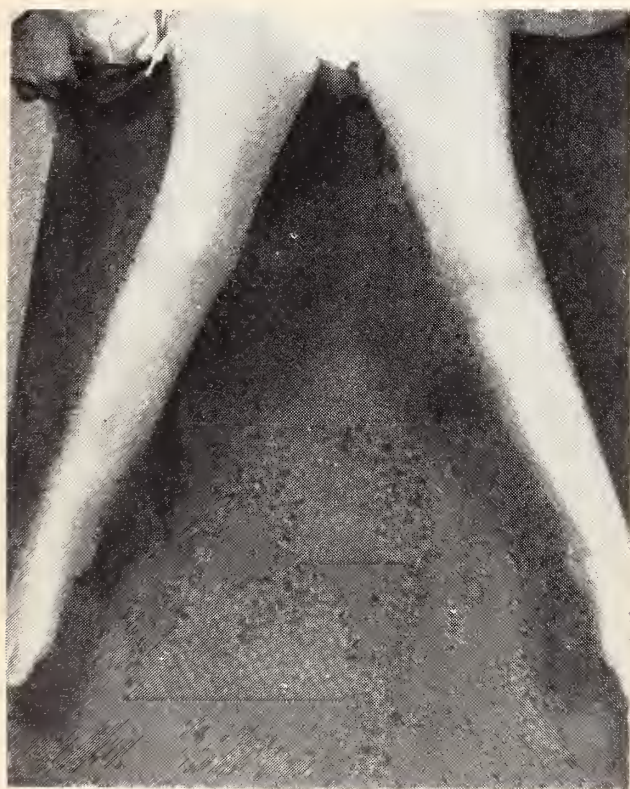


Figure 3. Abduction contracture of hip. Same patient as Figure 2. Legs cannot be brought together in adduction beyond this point.

is in a different plane of action. A rotational tibial and fibular osteotomy is necessary to bring the foot into a normal weight bearing line with the knee. For severe knock knee, a femoral osteotomy is necessary for alinement of the leg so it will fit into a brace.

Poliomyelitis retards longitudinal growth of bone. One leg may be shorter by several centimeters. This problem of leg length discrepancy is ameliorated by a growth arrest of the longer leg at a calculated period in the growing child's life. This enables the two legs to become approximately equal in length. Building up the shoe of the shorter leg will produce a leveling of the pelvis and a more normal gait. An apparent shortening of one leg may result from a tilted pelvis and would require a different evaluation from an actual leg length discrepancy.

Without the hip flexors, especially the ilio-psoas, the thigh is not flexed sufficiently to get the leg off the ground. This inability is off-set by the "hip hikers"—the quadratus lumborum and the latissimus dorsi. These "hikers" raise the hip so that the leg is clear of the ground and with a swinging forward of the pelvis, the leg is thrown forward for the step. The sartorius muscle, which may be spared, is often sufficient to flex the thigh.

Another cause of limp in polio is weakness of the gluteus medius. This is the powerful abductor of the thigh. In standing, the gluteus medius of one side keeps the normal man from falling to the opposite side at the hip joint. With this muscle gone or weakened, the patient tends to fall to this opposite side. He counteracts this falling tendency by changing his weight bearing axis so that no abduction of hip is necessary. This he does by throwing his trunk to the side of the weak gluteus medius. Therefore, the marked limp is to the side affected so as to bring through the opposite extremity in walking. When bilateral involvement is present, the patient walks with a "waddling" gait. As the patient puts weight on the affected side, the opposite side of the pelvis drops, or he leans toward the weak gluteus medius. This is the Trendelenburg sign, which is also seen in congenital dislocated hip.

Genu recurvatum is not uncommon in polio. Hyperextension develops often when the quadriceps is weak to give stability to the knee. A little equinus helps a weak quadriceps by giving slight hyperextension of the knee. When recurvatum is severe, an osteotomy may be necessary for correction of this deformity. Protection of the knee with slight flexion during the acute phase is helpful in preventing this deformity. Stability of the knee is primarily a function of the quadriceps. However, some stability comes from the gluteus maximus, hamstrings and triceps surae.

The foot is frequently deformed by poliomyelitis. These deformities are varied. Varus and equinovarus are not uncommon. These patients walk on the outside of the foot and their gait is usually clumsy. Varus is due to muscle imbalance at first, with fixed deformity of the foot occurring later if the condition is allowed to persist. A calcaneus foot shifts the weight axis so that the patient walks on his heel.

There is no "take-off" since the heel is the contact area while the foot is supporting the body. The foot is often in cavus. The gait in this condition is similar to a prosthesis (artificial leg). Cavus may be present due to tightness or contracture of the plantar fascia. Paralytic dropfoot produces a slapping gait, which is highly characteristic. Treatment of the foot includes such measures as stabilization. Release of any con-

tractures is important (e.g. heel cord lengthening and plantar fasciotomy). Tendon transfers give new function, help strengthen weakened structures, or decrease deforming forces acting on the foot.

SUMMARY

Muscle imbalance and deformities are frequent in paralytic poliomyelitis. These necessitate compensation and correction to aid the patient in walking.

MECKEL'S DIVERTICULUM

as a Cause of

INTUSSUSCEPTION

BRIT B. GAY, JR., M.D., TED F. LEIGH, M.D.

and JAMES V. ROGERS, JR., M.D., Atlanta

Meckel's diverticulum is a common and well recognized anomaly of the small intestine. This diverticulum results when there is failure of the omphalomesenteric duct to close during fetal development. The anomaly consists of an outpouching of the ileum from its antimesenteric border and is located usually between 18 and 36 inches from the ileo-cecal valve, but may be within 4 cm. of the ileocecal valve. It is a true diverticulum in that its wall contains all of the intestinal coats. Mucous membrane lining the structure frequently contains aberrant cells which may be of gastric or pancreatic origin and less commonly of duodenal or colic origin. Meckel's diverticulum occurs in about 2 per cent of the population.¹⁰ Howell⁹ estimates that one-fourth of these people have symptoms and complications resulting from Meckel's diverticulum. These complications may fall into the following groups:

(1) *Acute inflammation (Meckel's diverticulitis)* may result following occlusion of the lumen and simulate very closely the signs of acute appendicitis.

In Howell's series of cases 60 per cent of 61 patients had a preoperative diagnosis of acute appendicitis.⁹

(2) *Perforation* may follow the acute inflammatory process. This occurred in 3.2 per cent of one series.⁹

(3) *Hemorrhage* may follow acute ulceration within the diverticulum. The presence of aberrant gastric mucosa is an important factor in the development of ulceration which may occur adjacent to but not in the aberrant tissue. Ten per cent of Howell's series showed intestinal bleeding. This complication should be considered as a diagnostic possibility in any patient in whom intestinal bleeding can not be explained. Roentgenographic examinations are of little value in this complication since the presence of the anomaly is only very rarely demonstrated with barium studies.¹⁻⁴

(4) *Mechanical intestinal obstruction* may result from adhesions developing about a Meckel's diverticulum. Twelve per cent of Howell's series⁹ showed clinical obstruction preoperatively.

(5) *Tumor formation*, benign and malignant, within a Meckel's diverticulum is a rare complication.²

From the Department of Radiology, Emory University Hospital and School of Medicine, Emory University, Ga.

(6) *Intussusception* following invagination of the diverticulum into the ileal lumen occurred in one of 61 cases in Howell's series. Harkins states that intussusception is present in 17 per cent of symptomatic Meckel's diverticula.⁷

It is with this last mentioned complication that this report is concerned. In the last year we have seen two cases of intussusception produced by an invaginated diverticulum. One case has been previously reported from a radiographic standpoint in radiology.¹³

The earliest reported case of intussusception of Meckel's diverticulum is said by Harkins⁷ to be that specimen placed in the St. Bartholomew's Hospital Anatomical Museum in 1846. In 1933, an extensive review of literature by Harkins produced 160 cases which he analyzed.⁷ Other authors since have reported additional cases. The total number of cases reported exceeds 250.¹³

The largest majority of cases of intussusception due to Meckel's diverticulum occurred before the age of puberty, but Greenfield and Smoak have stated that at least 80 cases have been reported in adults.⁵

The pathogenesis of intussusception in Meckel's diverticulum is as follows: The diverticular pouch invaginates into the ileal lumen and acts as a polypoid mass which the intestine attempts to propel along the lumen through vigorous peristalsis. This invaginated diverticulum acts in the same manner as other polypoid lesions (polyps, lipomas, lymphomas, etc.) of the small bowel which produce intussusception. The diverticulum then becomes the head of the intussusception and forms the intussusceptum. The distal intestine into which this invaginates becomes the intussusciptens.

The intussusception may be acute and produce acute intestinal obstruction or the obstruction may be incomplete and more chronic. Repeated attacks are not infrequent before diagnosis is finally established at operation.

Clinically, cramping peri-umbilical pain is a prominent feature. This is associated with nausea and vomiting in most cases. Intestinal bleeding may result from the intussusception *per se* or may be the result of ulceration in the diverticulum as one of the cases reported herein. In the younger patient, a palpable mass is usually present in the right lower abdomen.

Radiologic findings may fall into one of several groups:

(1) Complete or partial small bowel obstruction if present may be evident on routine films of the abdomen (Fig. 3).

(2) Barium enema will reveal an ileo-colic intussusception if this is present. A distal ileo-ileal intussusception may occasionally be shown on barium enema if there is good reflux of the barium into the terminal ileum.

(3) A small bowel barium clysis through a Miller-Abbott or Harris tube may reveal the intussusception as in our Case I (Fig. 1). This procedure is usually not possible in most cases because of the associated mechanical obstruction which does not allow extensive radiologic procedures. In a non-obstructed case,

however, this method is by far the most satisfactory one for demonstration of a Meckel's diverticulum. This procedure is of particular value in patients with unexplained intestinal bleeding. The demonstration of a Meckel's diverticulum in such a case would be of considerable importance in diagnosis and management of these patients.

(4) Negative radiologic findings are present in some cases. Negative radiologic studies can not be used to exclude a Meckel's diverticulum with certainty.

Treatment in these patients is invariably surgical, with resection of non-viable bowel if present. If the intussusception can be reduced and if vascularity of the bowel is not impaired, simple removal of the diverticulum is the treatment of choice.

The following cases both came to surgery, the diagnosis being made only after surgery.

CASE REPORTS

Case I. (Previously reported by Gay¹³) F.D.F., a 31-year-old white salesman was admitted to Lawson VA Hospital May 22, 1951. Two weeks before admission he developed colicky periumbilical pain following a laxative. This pain lasted for about 13 hours, and he was seen as an out-patient with radiographs of the abdomen and chest being within normal limits. Following this, he had daily attacks of mild colicky pain up until three days before admission, at which time, he developed a rather severe watery diarrhea. The day before admission, he began having moderately severe periumbilical pain associated with melena. The stools became tarry, in addition to containing moderate amounts of bright red blood. He had associated weakness and anorexia, but no



Fig. 1. Case I. (Previously reported in Radiology.) Small bowel series. An ileo-ileal intussusception is demonstrated with origin at A, barium in the intussusception (D), barium in the intussusception (E), filling defect of bowel forming intussusception (C), and the head of the intussusception formed by the Meckel's diverticulum (B).

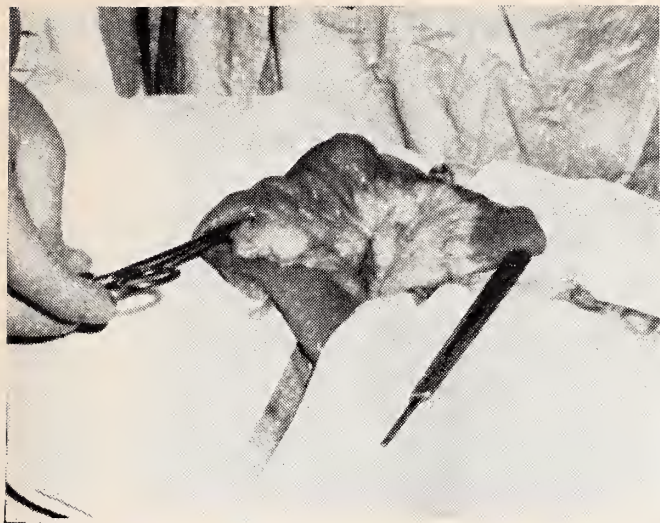


Fig. 2. (a) Case I. The ileo-ileal intussusception. Hemostat marks arigin. (b) After partial reduction of the intussusception the



Meckel's diverticulum is shawn (M.D.). Nate marked edema af bawel wall.

vomiting. Past history revealed an appendectomy four years previously.

Physical examination on admission showed pale skin, some tenderness in the lower abdomen on both sides, no rebound tenderness, hyperactive peristalsis, and a questionable mass palpable in the right lower quadrant. Rectal examination was negative.

Laboratory data: Hemoglobin was 7.9 grams with a hematocrit of 25 mm. Stool examination showed 4 plus of cult blood. White count was 16,700 with a normal differential.

Radiologic studies of the chest and abdomen were within normal limits. A barium enema was done on the second hospital day which showed no abnormality. Following this on the same day, an upper G. I. Series was done, and on the three hour film, there was noted a filling defect within the distal ileum suggestive of a tumor mass. The following day, a Harris tube was passed into the small intestine and small bowel barium clysis was done (Fig. 1). There was noted at this examination a temporary delay in the passage of barium through the distal ileum and a filling defect within the lumen of the distal ileum. There was also suggested extrinsic pressure along the bowel margin. Barium passed then without obstruction to the cecum. It was the radiologic opinion that the patient had an intramural tumor mass in the distal ileum, probably a lymphoma. The diagnosis of a Meckel's diverticulum was suspected by two of the surgical residents.

Hospital Course: Patient was given several transfusions and prepared for surgery with a presumptive diagnosis of a small bowel tumor. On May 25, 1951, under spinal anesthesia, the abdomen was opened through a transverse incision 2 cm. below the umbilicus. Near the cecum, at a distance of three feet from the ileo-cecal valve, a firm elongated mass, involving the bowel was palpated, and delivered into the wound. The mass measured 10 inches in length, and on inspection, was found to be an ileo-ileal intussusception (Fig. 2). The intussusception could be only partially reduced. A Meckel's diverticulum was found invaginated into the central portion of the mass. A 12-inch segment of ileum was resected and an end to end anastomosis was done. The intussusception could only be partially reduced.

Pathological diagnosis on the surgical specimen was "Meckel's diverticulum with chronic ulcer in the diverticulum, and an intussusception into the ileum."

Case II. C. H. A., a 20-year-old white female was admitted to Emory University Hospital, January 18, 1952, in labor which progressed normally to delivery of a healthy full term baby boy.

On the following day the patient began to have nausea and vomiting, and developed mild abdominal distention with intermittent cramping pain. These symptoms continued during the following 48 hours. Radiographic studies of the abdomen revealed gas-distended small intestine with very

little gas in the colon. A repeat examination 48 hours later showed an increase in the amount of small bowel distention (Fig. 3). The patient developed increased peristalsis with generalized abdominal tenderness and further nausea and vomiting.

On January 21, 1952 at 7:30 P. M. the patient was taken to the operating room for exploration with a preoperative diagnosis of small bowel obstruction. At operation, an ileocolic intussusception was found involving the terminal 14 inches of the ileum. This ileum had intussuscepted about eight inches into the ascending colon. At the head of the intussusception was an invaginated Meckel's diverticulum

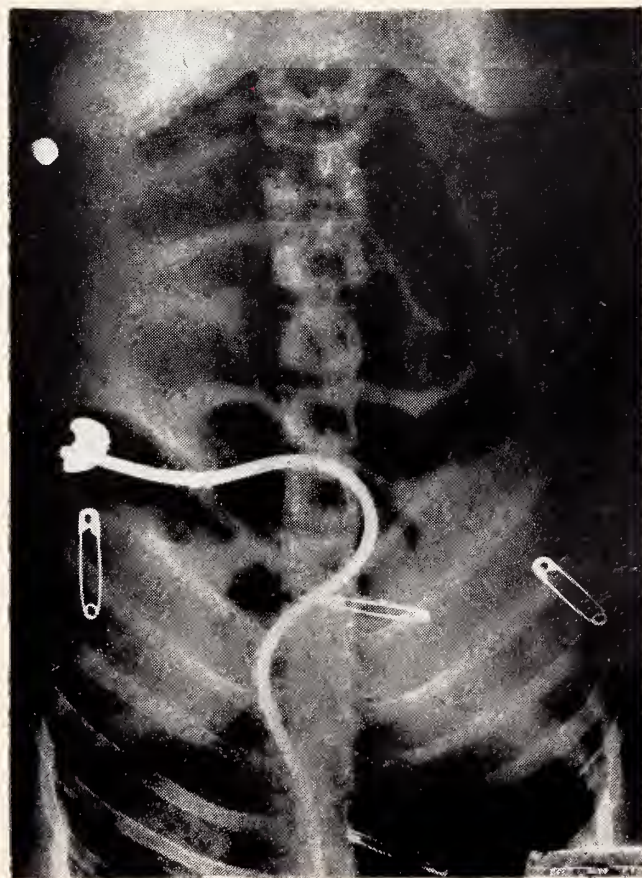


Fig. 3. Case II. Radiograph of abdomen shawing small intestinal abstruction.

measuring 4 cm. in length and 3 cm. in greatest diameter. Ten inches of gangrenous terminal ileum had to be resected along with the diverticulum (Fig. 4). The patient made an uneventful recovery.

Pathological diagnosis on specimen was "Gangrene of the small intestine; acute ulcerations of the intestine; Meckel's diverticulum showing gastric mucosa. Normal appendix."

SUMMARY

Two cases of invaginated intussuscepted Meckel's diverticula have been presented. Meckel's diverti-

culum is a common anomaly of the ileum and complications arising from this anomaly should be considered in any acute abdominal condition or gastrointestinal hemorrhage. It has been stated that intussusception occurs in about 17 per cent of the symptomatic Meckel's diverticula.

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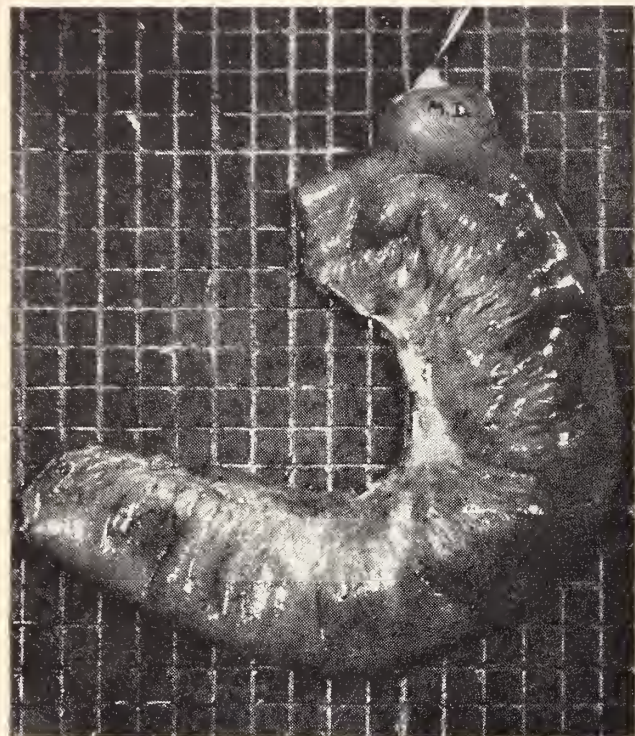


Fig. 4. Case II. Surgical specimen after resection showing Meckel's diverticulum which produced an ileo-colic intussusception.

Data on Doctor's Incomes

The average physician in private practice had a 1951 net income, before taxes, of \$15,262—a rise of 35 per cent in four years.

This is revealed in the December issue of *Medical Economics*, national business magazine for doctors.

According to their survey, the average U. S. doctor is in a better financial position now than at any time in the past. But physicians' incomes are found to vary widely when regional and other breakdowns are made.

The farther West a doctor practices, says *Medical Economics*, the higher his income is likely to be. Thus, physicians in New England and the Middle East have the lowest incomes in the country, while those in the Far West have the highest.

The following table gives the average 1951 net incomes of physicians by regions: New England—\$12,158; Middle East—\$12,938; Southeast—\$16,048; Southwest—\$15,947; Central—\$16,928; Northwest—\$16,431; Far West—\$17,900.

Doctors' incomes tend to be highest in cities of 50,000 to 500,000, lowest in cities of more than 1 million. Of the ten largest U. S. cities, Cleveland and St. Louis show the highest physicians' incomes, and New York, Philadelphia, and Boston the lowest.

The magazine also found that incomes are generally highest among medical men with from 10 to 20 years in practice. They're lowest among those with 30 or more years' experience.

NON-PENETRATING *Injuries of the*

ABDOMEN

The alarming increase in the frequency of automobile accidents within the past decade has aroused an increased interest in and greatly emphasized the value of the proper treatment of non-penetrating injuries of the abdomen. This is particularly true since a greater number of these injured people are now being handled in the smaller hospitals which are closer to the scene of the accidents. They are being handled by men who are not primarily surgeons. It is upon these men, nevertheless, that the responsibility rests in deciding as to whether or not surgery is indicated in some of these patients.

This brief essay will attempt to present some of the pitfalls in the diagnosis and treatment of these cases. In the first place, it should be stressed that there is a higher incidence of abdominal injury in conjunction with other multiple injuries elsewhere about the body, than is commonly realized. In these instances it is easy for the doctor to become preoccupied with the more obvious injuries and neglect the possibility of the presence of the less apparent abdominal injury. It is natural that this should be so. A fractured skull or a broken neck or multiple complicated fractures are all dramatic injuries that arrest and demand attention. Conversely, when one considers that the true nature and full extent of severe damage to the intra-abdominal organs, may be concealed behind abdominal walls, which show no evidence of injury whatever, it is not surprising that the examiner may presuppose that because of the absence of marks of external violence that no injury exists. The frequency with which certain extra abdominal injuries produce physical signs simulating those occurring in actual abdominal injury further complicates the picture. This is particularly true of injuries of the spine and thorax. That this is so arises from the fact that the abdominal walls receive their innervation from the lower six thoracic nerves. These nerves proceed from the spine subcostally to their respective segments of the abdominal wall and injury to the spine or thorax in the region of the course of these nerves produces referred sensory pain, tenderness, hyperesthesia and reflex motor spasm. These are localized in the abdominal wall as well as present at the site of the injury. In occurrences of this nature there is a likelihood that the examiner may assume from the physical signs present that an abdominal injury exists, when in reality there is none.

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These obvious pitfalls may be avoided first by an adequate, thorough and complete physical examination of the injured patient, with careful evaluation of all of his injuries. Immediately after nearly every accident the patient is badly frightened, the muscles are tense and twitchy and they are inclined to exhibit tenderness in any area palpated. This psychic reaction to fright and pain should gradually disappear in a period of one to two hours, leaving the patient quiet and comfortable. This is particularly true if the elapsed time has been utilized in the treatment of the patient's other injuries, which may be present. Fractures, for instance, may be splinted without attempted reduction, lacerations may be sutured and dressed and supportive measures instituted and x-rays made where indicated. If visceral injury has occurred, this can be much better determined by re-examination after this initial reaction has disappeared. Then the symptoms and signs of the damaged viscus will become more and more obvious. X-rays of the abdominal region can be particularly helpful in some cases. If, for example, free air in the peritoneal cavity can be satisfactorily demonstrated, it is undeniable evidence of a rupture or perforation of an air containing viscus. X-rays, of course, likewise will reveal the presence of a fractured spine, fractured ribs or a fractured pelvis. The intravenous pyelogram will often demonstrate whether or not a kidney may be involved. When all of these things are accomplished, and still no decision has been arrived at, the problem then resolves itself to one of watchful waiting and repeated examinations at frequent intervals and continuous observation of the patient in order that any change in his condition may be quickly noted. By so doing, the increasing signs of spreading peritoneal irritation and intraperitoneal hemorrhage will not pass unnoticed, and valuable time will not be lost.

There are certain other pitfalls, which we may fall into, if we fail to consider certain

peculiarities of the abdominal organs themselves. For instance, while practically any abdominal organ sustaining injury sufficiently severe is capable of producing grave, or even fatal blood loss, there are certain organs which are notorious in this respect. These are the spleen, the liver, and the kidneys, which because of their vascularity and structure are particularly liable when injured to produce a treacherous type of hemorrhage.

In regard to the hollow organs it should be recalled that when they are empty they are much less liable to injury than when they are full, and in the event of perforation or rupture the discharge of the inflammatory content is considerably less. It is also important to bear in mind that when the hollow viscera are filled with fluid or air and force is applied, such force is transmitted to occur at its weakest point. This accounts for the bursting lacerations occasionally observed in both the large and small bowel, which are removed from the site of injury. For example, a rupture of the cecum may occur from a blow sustained in the region of the transverse colon. The occurrence of visceral injury remote from the site of application of the force is likewise accounted for by two other factors. The first of these is the disposition of the peritoneal bands and attachments which limit the motility of the viscera to which they are affixed. This factor is especially likely to influence the site of perforation or laceration in trauma sustained by the application of force to the abdomen which produces a sudden and violent shift of position of its visceral content. In such instances, the motile parts of the viscera (for example, the large and small bowel) move readily in the direction of the force, but their attached parts remain relatively stationary, resulting in undue stress with possible separation or tearing of the visceral wall at the site of the peritoneal attachment: for example, rupture of the small bowel at the ligament of Treitz, and traumatic lesions of the colon along the lines of attachment at the hepatic and splenic flexures, resulting from blunt force applied to the abdomen. The second additional factor is the possible presence of pre-existing visceral disease. In such instances when the viscera have been previously altered by pathological processes prior to injury, applied force of otherwise innocuous degree may produce extensive lesions. Such are liable to occur in aged, chronically ill or otherwise debilitated individuals.

The character of the content of the hollow viscera is worthy of consideration since there is significant variation in its effect when discharged into the free peritoneal cavity. The content of all hollow viscera is inflammatory by reason of the presence of irritating chemical compounds and pathological organisms. Generally speaking the pathogenic bacterial content in the gastrointestinal tract increases from above downward, while its irritant-containing chemical secretions decrease. Thus it may be deduced that when the content of the stomach

and small bowel is discharged into the free peritoneal cavity, the inflammatory reaction tends to be immediate and severe and the signs indicative of peritoneal irritation marked, while with the intraperitoneal leakage of large bowel content, the inevitable inflammation may be extensive and severe, but it will take longer to develop and the signs at the onset are much less marked. The chemical constituents of bile and urine provide a characteristically severe form of peritonitis after a short latent period, whether these fluids are sterile or not.

Whenever severe injury is sustained to any intra-abdominal viscus there is practically always a reflex inhibition of intestinal peristalsis. This is prone to occur at or very soon after the time of injury and it continues for a variable period, according to the extent of the trauma. Usually when a perforation or rupture of a hollow viscus has been produced with consequent discharge of its inflammatory content into the peritoneum, the peristalsis diminishes with the increasing inflammatory reaction. Even in the event that no intraperitoneal discharge of visceral content or hemorrhage has occurred, contusion of the viscera may produce the same effect. In any instance, therefore, of potential intra-abdominal injury, the activity of the peristalsis should be continuously observed, for its absence taken in conjunction with other findings is a very significant sign of visceral injury. It should not be forgotten that retroperitoneal hemorrhage may produce the same picture. In rupture of the kidney, of course, the hemorrhage is mostly retroperitoneal and the reflex inhibition of peristalsis which is produced is indistinguishable from that which occurs in a true intraperitoneal injury.

Therefore, it may be fairly said that the principal decision confronting the physician is whether or not sufficient injury to the contained abdominal viscera has been sustained to warrant exploration. In any instance of injury in which the abdomen is doubtfully involved it is imperative that in addition to constant observation, supportive treatment be carried out in the same manner as it would be carried out in the event that injury actually existed. If this plan is followed, no time will be lost should trauma later be proven to be present. In instances of abdominal injury in which after a period of close observation and treatment the examiner cannot be sure as to whether or not visceral damage exists, the performances of an exploratory laparotomy is mandatory. The rationale of this course is apparent from the fact that the chances for survival, in most individual cases, are far better if a laparotomy is performed, which yields negative findings than if severe intraperitoneal hemorrhage or spreading peritonitis is missed through excessive caution on the part of the physician. Once laparotomy is undertaken the possibility of visceral injury remote from the site of application of the force must always be considered. This possibility makes it mandatory that a complete exploration of all the viscera must be done, once an operation has been decided upon.

Treatment of the ALCOHOLIC

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Today, the illness of alcoholism is one of grave public concern. To most physicians and especially to those of us interested in psychiatry, alcoholism presents a challenging problem. It is a public health problem, now well recognized by other professional and interested lay groups such as this one, and through our united efforts we hope to make some progress in a campaign for effective control. As with any disease, this illness requires the knowledge of the cause, prevention, early recognition and adequate treatment of alcoholism, combined with public education, research, community planning and action.

Any one of these aspects of alcoholism could provoke lengthy discussion. This evening, however, I have been asked to tell you something about the treatment of the alcoholic patient, the treatment according to modern and generally accepted medical opinions, which leaves much to be desired, and which we hope, with more study and research, eventually will become more uniformly successful. The many details about treatment can be mentioned only in the form of an over-all summary. In the motion picture to follow you will have the opportunity to see an excellent example of this treatment process in action.

First, a word about the nature and cause of the illness of alcoholism is timely, for therein lie the reasons for our present method of treatment. There is much we do not yet know about the cause. Recent observations and research have prompted the suggestion that it is the result of some disturbance in metabolism, in nutrition or in certain glandular functions of the body. Nevertheless, the currently accepted medical opinion is that the basic or primary cause of alcoholism is psychologic or emotional, rather than physical in nature. The abnormal and uncontrollable use of alcohol is, therefore, a dominant symptom of the emotional illness. There are important physical symptoms, too, but these are

thought to be secondary and the result of excessive alcohol and impaired nutrition. Because of the psychologic nature of the primary illness, which can vary from a mild and temporary one to one which is most severe and incurable, any method of treatment must include a personality study and evaluation of the alcoholic patient, and knowledge of his personal and interpersonal relationships and of his environment, including his social and vocational adaptation.

The usual alcoholic personality is characterized by varying degrees of emotional immaturity. This might be due to an arrested emotional development on an immature level, or to a regression to an immature pattern of behavior because of suppressed and unresolved conflicts, frustrations, inability to accept reality and the need for escape in neurotic behavior. Even in the apparently well adjusted and emotionally mature person, there are sometimes prominent but well controlled neurotic traits. These may remain insignificant so long as the person is not under unusual stress or pressure from physical or emotional causes, but when he is, these features of his personality can become disturbing.

It is well known that the depressant or narcotic effect of alcohol not only gives prompt and welcome relief to such stress reactions, but its regular and repeated use aggravates the degree and lessens one's physical and emotional efficiency in dealing with it. As a result, there is greater need for relief or escape, and more and more need for alcohol. This vicious circle becomes malignant, and unless there is an early effort to interrupt it, the breakdown is inevitable. The alcoholic addict's neurotic behavior then becomes exaggerated; he breaks with his family, his job, his friends; there are inner feelings of anxiety, guilt, insecurity, loneliness, unhappiness and despair; outwardly he is irritable, antagonistic, suspicious, jealous, hostile, resentful and defiant. His attitude is distorted to the extent that he rebels against those who try to help him most, and there often appears little, if any, chance to gain his obstacles to a successful rehabilitation. We must understand this reaction as an illness, not as a weakness, an immoral, illegal act, or just plain stubbornness. With a tactful and scientific approach by the family, friends, doctors, courts, judges and

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even the public, much can be done to break through the iron curtain of defense.

When the emotional disturbance is less severe, the alcoholic patient frequently exercises his own initiative and determination; he understands his illness and his need for control, and may succeed in making a complete recovery. This can be accomplished alone, but more often occurs with healthy attitudes and words of encouragement from relatives, friends, his minister, and Alcoholics Anonymous, or with a minimum amount of medical or psychiatric treatment. Unfortunately, there are many persons suffering from alcoholism today who need something more, those who apparently want help and have tried the methods mentioned once or many times without success, and those who have reached such a state that little if any desire for recovery seems evident.

As many state commissions have done, the Georgia Commission on Alcoholism has made provisions not only for the treatment of voluntary patients but also for those who, with their serious illness, are a menace to themselves, to their families and to society. If enforced treatment is necessary, it must be given as the only hope for their recovery, and, as is clearly recognized, not as a punitive measure.

TREATMENT

For any alcoholic patient the goal of treatment is to attain an acceptable, a mature and a reasonably stable readjustment of his life on a level of complete and permanent abstinence from alcohol. If he fails to accomplish this without medical help, then the following plan of treatment should be instituted:

1. Study, evaluation and treatment of physical needs.
2. Study, evaluation and treatment of psychological or emotional needs.
3. Plans for social, spiritual, and vocational re-education and rehabilitation.

PHYSICAL REHABILITATION

Hospital treatment is necessary when there are serious physical or emotional symptoms, if abstinence cannot be attained and maintained for at least three or four consecutive weeks, or if sobriety cannot be reached from other methods during a spree. The period of hospitalization for successful initiation of treatment should be a minimum of two weeks and should be extended sufficiently to meet individual needs. As soon as he is well enough, the alcoholic patient is encouraged to return to his occupation while outpatient treatment is started.

Sobering-up is a painful process and deserves considerate and sympathetic treatment. Care is necessary to detect and treat the common complications such as delirium, convulsions, gastric hemorrhages and malnutrition.

General supportive measures for the physical needs are rest and a well balanced diet with frequent ingestion of liquids such as milk and fruit juices with dextrose. Vitamin concentrates are valuable, but help only when nourishment is taken. They are not a substitute for food. In the presence of dehydration intravenous dextrose and saline solution, at times

with insulin, are necessary.

Sedatives are sometimes necessary and, when given, should be of the mildest type, and used most sparingly, if at all, when they are to be taken outside a hospital. Every alcoholic patient is susceptible to addiction to all the common nerve sedatives, sleeping drugs and narcotics. Especially dangerous are the sleeping drugs known as barbiturates, all opiates and the newer opiate-like synthetic drugs, demeral and methadone. There are many drug addicts today because of the careless use of drugs in the treatment of alcoholic hang-overs.

Other medicinal treatment can be helpful. In the past few years certain new drugs, mephensesin, myanesin and tolserol, which are not habit-forming and have little if any toxic side effects, are useful in the control of nervousness, tremors and severe emotional tension during the hang-over period. Their continued use also can relieve mild states of nervousness and tension which often return during the first few months of abstinence.

The hormones of the pituitary and adrenal glands, popularly known as ACTH, ACE, and cortisone, have proved useful in the early treatment of the alcoholic patient. ACTH is helpful in terminating severe delirium. ACE and cortisone have been effective in speeding the recovery from immediate discomforts of intoxication and in hastening withdrawal and abstinence. The initial enthusiasm, however, about the adrenal hormone as a "cure" or a treatment of lasting effect has dwindled rapidly. The continued use of ACE does not change the desire to drink, nor does it give any protection against drinking.

During the first year of treatment the greatest task for an alcoholic patient is the effective control of his drinking. Until his psychological readjustment is more complete, he is still subject to his old impulses, urges or compulsions to have "just one and no more", always followed by the old pattern of "a gallon is not enough." So-called aversion treatments have been devised to help the patient manage his control more effectively.

The conditioned reflex treatment is based on the association of drinking with severe nausea and vomiting, which are induced during the conditioning process by the injection of such drugs as emetine or apomorphine. When combined with other methods of treatment, especially psychotherapy, this aversion has been helpful, but it has not been sufficiently lasting to justify the added suffering and risks involved.

In Denmark about four years ago another form of aversion to alcohol was found possible when a person takes the drug known as antabuse or disulfiram (tetraethylthiuram disulfide). This aversion is somewhat different in that no ill effects are noticeable from the small daily dose of the drug alone, but when even the smallest amount of alcohol is taken, there is a prompt, most unpleasant and undesirable reaction. Continued drinking is impossible because of the intense discomfort, nausea, vomiting and

weakness which result. A few hours after such a reaction the patient feels relaxed with no desire for another similar experience. The drug is absorbed and excreted slowly, so that after a few doses, its effect will last for about a week.

In addition to its use for control, other advantages of disulfiram are: (1) It has a helpful sedative effect without habit-forming qualities. (2) Because of the early protection it affords the alcoholic patient, it enables him to carry on sooner outside the hospital and to save on the expense of treatment as well as to resume his occupation and to re-establish his income. The use of this drug is not a "cure." It is intended for more effective control during the period of active psychotherapy and rehabilitation. It can help only when it is accepted for such purpose voluntarily, and should never be given without the patient's knowledge and consent. No serious toxic effects are known, but disulfiram should be used cautiously, under the doctor's direction and always combined with the more important steps in treatment. It is used now for selected patients in almost all alcoholic clinics, and the results in our experience and from other clinics are sufficiently encouraging to warrant its continued use. With the proper precautions, disulfiram is considered safe. In some cases it has been used almost continuously without trouble for two or three years. Most patients are advised to take it for at least a year, and with the understanding that complete abstinence without disulfiram or any other drug is necessary for successful recovery.

PSYCHOLOGIC REHABILITATION

The most important phase of treatment of the alcoholic patient is the process of psychologic rehabilitation. With a desire to be well, he must be willing to understand and accept the fact that his drinking is merely a symptom of an emotional illness of some degree, and that proper treatment of the illness is his only chance for recovery. He is encouraged to discuss his illness freely and frankly with his doctor, to exercise his best and most mature judgment and his own initiative, to make his own decisions and to meet and solve his own problems. By means of regular and frequent interviews and discussions with his doctor alone, at times with members of his family and in group sessions with other patients, he attains healthier, more mature attitudes and behavior. He learns to avoid his old immature habits of escape and to face and accept reality as it is. He learns to make the best of it to the extent of his ability, striving to succeed on his own when possible but willing to seek help when needed. All this must be on the premise that he can never become a moderate drinker, and that permanent and complete abstinence is necessary. Ultimately, his determination and conviction grow to the point of complete satisfaction in sobriety. He can be a controlled alcoholic, but never cured.

Briefly enumerated, the steps toward this psychologic readjustment and rehabilitation are:

1. Healthy and helpful attitudes of family, friends, employers, social workers, ministers and the public to encourage rather than discourage the approach

of an alcoholic patient to treatment.

2. The establishment of the doctor-patient relationship to the point of successful treatment. When this fails, the psychiatrist makes a careful study of the reasons and best methods of handling the problem. An evaluation is made of the patient's insight and of the degree of his competence. In the beginning the patient may be skeptical, resistive and even rebellious, but often a tactful approach will be rewarded by a change to an attitude of acceptance.

3. Should it be necessary for treatment to begin without the patient's consent or desire, it is the duty of the doctor, preferably a psychiatrist and his staff of co-workers, to do all possible to establish a confident professional relationship which will result ultimately in the patient's desire for help and continuation of treatment on a voluntary plan.

4. Fundamental rules for treatment require that there be:

- (1) An honest and sincere desire to accept treatment without force or threats.
- (2) An honest desire to remain abstinent during treatment, and to consider use of all possible measures of control, including Alcoholics Anonymous and disulfiram.
- (3) A willingness to make and keep appointments.
- (4) Complete frankness with the therapist.
- (5) An understanding that he will be treated like an adult.
- (6) A desire to place his treatment ahead of all other activities for a while and to feel that getting well is paramount.
- (7) Individual and group discussions with relatives.
- (8) Protective and preventive interviews when needed or requested.

5. The patient is encouraged to attend and participate in a group of Alcoholics Anonymous. In this organization there is a unique opportunity for all persons with alcoholism to benefit from mutual understanding and assistance, group therapy, and the 12 steps which are the layman's translation of rational psychotherapy. In summary, Alcoholics Anonymous describes the meaning of these steps as: "(1) Admission of alcoholism; (2) Personality analysis and catharsis; (3) Adjustment of personal relations; (4) Dependence upon some Higher Power; (5) Working with other alcoholics." This is good medicine; it is good psychiatry operating successfully by alcoholics and for alcoholics. In Alcoholics Anonymous it has been well established that one alcoholic addict can often penetrate the firm resistance of another to treatment when others have failed. The value is chiefly the use of religion to bring about a "spiritual conversion."

RE-EDUCATION AND REHABILITATION

The foregoing methods for physical and psychologic treatment comprise what can be termed one's personal readjustment. Much more is required for a complete state of well-being. The alcoholic patient must re-educate and readjust himself to society—in relation to other people. They include his family,

his friends, his fellow workers, his employer, his minister and even his physician. Social, vocational and spiritual re-education enhances the alcoholic's interpersonal readjustment and complete rehabilitation. The process is slow and tedious; it requires effort, determination and conviction. In Alcoholics Anonymous this opportunity is afforded without equal.

PREVENTION

In addition to these corrective measures there is the important subject of prevention. For the prevention of alcoholism we must rely on (1) the principles of mental hygiene, (2) public education, (3) research and (4) community planning and action.

It has been said that "alcoholism cannot take root in adult emotional soil." By means of mental hygiene a person is best able to attain and maintain emotional maturity and in turn have his best chance for mental health. It is obvious that this training should begin in early childhood. Without further elaboration, suffice it to say that from infancy to adult life, and even into senescence, the knowledge and practice of sound principles of mental

hygiene will assure one of a healthy psychologic development and a mature, well integrated and reasonably stable personality. When one fails to accomplish this end, he becomes more susceptible to the pressures and stresses of life, to a reaction which we call neurotic or escape behavior, and with alcohol this is easily and quickly transformed into a more malignant behavior of escape—uncontrolled drinking.

Further help toward prevention can come from intelligent instruction as to the dangers of heavy social drinking. Too often this is the first step to alcoholism.

In our over-all plan of treatment there must be a coordination of public education as to the nature of alcoholism, its prevention and treatment and continued research to further our knowledge of this illness in all of its ramifications. This has been started by the National Committee on Alcoholism, The Committee on the Study of Alcoholism of the National Research Council, The Yale School for the Study of Alcoholism and the Yale Plan Clinic, similar clinics and research centers and the Commission on Alcoholism in the various states.

Georgia Survey to Evaluate Needs of Crippled Children

Present facilities and future needs of Georgia's 100,000 handicapped children are being evaluated by Dr. Samuel M. Wishik, of the University of Pittsburgh Graduate School of Public Health and School of Medicine, in a survey now being made through sponsorship of the Georgia Society for Crippled Children and the Cerebral Palsy Society of Georgia. Aim of the survey is to evolve a long-range program to dovetail the services of public and private agencies in Georgia.

Factual information brought out by the study will be of special interest to medical men professionally engaged in caring for this group of children. Thirty-one of these doctors are members of the survey's advisory committee. They include:

Pediatrics: Dr. C. Dixon Fowler, Atlanta; Dr. M. Hines Roberts, Atlanta; Dr. Richard W. Blumberg, Atlanta; Dr. Roger Dickson, Atlanta; Dr. Harry B. O'Rear, Augusta, and Dr. J. Harry Lang, Atlanta.

Orthopedics: Dr. J. H. Kite, Atlanta; Dr. H. Walker Jernigan, Atlanta; Dr. John L. Chandler, Augusta; Dr. Peter B. Wright, Augusta; Dr. Ruth M. Waring, Savannah; Dr. T. P. Waring, Savannah; and Dr. Robert P. Kelly, Atlanta.

Obstetrics and gynecology: Dr. John B. Duncan, Atlanta.

Plastic surgery: Dr. W. G. Hamm, Atlanta.

General practice: Dr. Peter Hydrick, College Park, and Dr. Wm. C. Cook, Columbus.

Neurology: Dr. Wm. A. Smith, Atlanta.

Internal Medicine: Dr. L. Minor Blackford, Atlanta.

Ophthalmology: Dr. Alton V. Hallum, Atlanta, and Dr. Morgan B. Raiford, Atlanta.

Otology: Dr. B. Russell Burke, Atlanta.

Dr. Norman Pursley, superintendent, Gracewood Training School; Dr. T. F. Sellers and Dr. Guy V. Rice, Department of Public Health; Dr. G. Lombard Kelly, president, Medical College of Georgia; Dr. C. F. Holton, president, Medical Association of Georgia; Dr. David Henry Poer, secretary, Medical Association of Georgia; Dr. Fred G. Hodgson, medical director, Crippled Children Services, State Department of Public Health.

Dr. Wishik has spent a good deal of time in Georgia since the survey was begun some months ago. He will continue to interview professional workers in the crippled children field and members of the Survey Advisory Committee.

Edgar P. Eyler, Savannah businessman and president of the Georgia Society for Crippled Children, and Mills B. Lane, Jr., Atlanta banker, who heads the Cerebral Palsy Society, said in a joint statement that the survey would be "a practical study" which they hoped would help develop a program for handicapped children that will point the way for other states to follow.

The Association

Report of SUBCOMMITTEE *on* HOSPITALS

The Committee on Hospitals (Sub-committee of the Committee on Public Health) met at the Academy of Medicine, Atlanta, at 5:00 p.m. on December 4. Members present were: Drs. C. L. Ayers, Toccoa; David Henry Poer, Atlanta; Hugh Wood, Atlanta; Thomas F. Sellers, Atlanta; R. C. Williams, Atlanta; E. M. Lancaster, Shady Dale; Lloyd C. Yeargin, Dalton; R. F. Spanjer, Cedartown; T. A. Sappington, Thomaston; W. D. Hazelhurst, Macon; Ernest Thompson, Monroe; and H. A. Goodwin, Summerville.

With Dr. Hugh Wood presiding, the committee discussed the following problems; (1) recruitment of nurses and nursing services; (2) training of nurses; (3) hospital problems of personnel and management; and the (4) services provided by Georgia Department of Public Health Division of Hospital Services.

The committee made the following recommendations:

(1) that the MAG and other interested groups explore the possibility of enacting legislation to enlarge nurses training programs at the Medical College of Georgia.

(2) that the committee further explore the problems of nurse recruitment.

(3) that the committee heartily commends the Division of Hospital Services, Georgia Department of Public Health for their activities concerned with the problems of personnel and management of hospitals in Georgia, but the committee recommends that the Association's approval of these services be referred to the MAG Council.

Dr. C. L. Ayers, Chairman of the Committee on Public Health, appointed Dr. Spanjer as Chairman and Dr. Sappington as Secretary of this newly formed Sub-Committee on Hospitals. The meeting was adjourned at 6:45 p.m.

Report of MAG COUNCIL

Executive Committee Meeting, December 8, 1952

The Council Executive Committee . . . comprised of Drs. H. Dawson Allen (Chairman), W. Bruce Schaefer, C. F. Holton and David Henry Poer . . . conferred via telephone conference call at 2:45 p.m.

The following action was taken:

1. *Recommended* written expression of gratitude be forwarded to Dr. Charles Richardson, Sr., of Macon, AMA Delegate, for his outstanding participation in the AMA Public Relations Conference, Denver, December 1.

2. *Authorized* travel expense of Chairman Frank Vinson of the Rural Health Committee for attend-

ance at the National Rural Health Conference, Roanoke, Va., in February 1953.

3. *Approved* sponsorship of national AAPS contest among Georgia high school students by the Woman's Auxiliary to the Medical Association of Georgia and *authorized* Association assumption of final cash awards in the sum of \$175.00 to top three winners thereof.

4. *Recommended* meeting of Council *in toto* be called in Atlanta on Sunday, January 11.

The conference call was concluded at 2:55 p.m.

Medical Association of Georgia

CONSTITUTION and BY-LAWS

CONSTITUTION AND BY-LAWS of THE MEDICAL ASSOCIATION OF GEORGIA*

CONSTITUTION

ARTICLE I.

NAME OF THE ASSOCIATION

The name of this organization is The Medical Association of Georgia.

ARTICLE II.

PURPOSES OF THE ASSOCIATION

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

ARTICLE III.

COMPONENT SOCIETIES

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

ARTICLE IV.

COMPOSITION OF THE ASSOCIATION

SEC. 1. The Association is composed of members and delegates.

SEC. 2. MEMBERS. The members of the Association are the members of the component county medical societies.

SEC. 3. DELEGATES. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

ARTICLE V.

HOUSE OF DELEGATES

SEC. 1. POWERS. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

SEC. 2. COMPOSITION. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

ARTICLE VI.

COUNCIL

SEC. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

(Section 2 now reads:)

SEC. 2. The Council shall consist of the President, the

President-Elect, the Secretary-Treasurer and one Councilor from each Congressional District in the State of Georgia.

(Section 2 will read:)*

SEC. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Councilor District in the State of Georgia.

ARTICLE VII.

SESSIONS AND MEETINGS

SEC. 1. ANNUAL SESSION. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

SEC. 2. TIME AND PLACE. The time and place for holding each annual session shall be fixed by the Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-third vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

DISTRICT SOCIETIES

(Now reads:)

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

(Will read:)*

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts which may be coextensive with the Congressional in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

ARTICLE IX.

OFFICERS

(Section 1 now reads:)

SEC. 1. OFFICERS. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

(Section 1 will read:)*

SEC. 1. OFFICERS. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor, or, in his absence, a Vice-Councilor, from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

SEC. 3. TERMS OF OFFICERS. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer and the Councilors who shall serve

*As adopted at the 102nd Annual Session of The Medical Association of Georgia, Atlanta, May 11-14, 1952.

*Subject to adoption at the 103rd Annual Session, in accordance with Article XIII of this Constitution.

for three years. One third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

ARTICLE X.

FUNDS AND EXPENSES

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget to the House of Delegates. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by Council, shall be included in the annual budget, subject to final approval by the House of Delegates.

ARTICLE XI.

OFFICIAL PUBLICATION

The official publication of the Association shall be THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget and abstracts of meetings of the Council.

ARTICLE XII.

SEAL

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII.

AMENDMENTS

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in THE JOURNAL of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

BY-LAWS

CHAPTER I.

MEMBERSHIP

SEC. 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

SEC. 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be *prima facie* evidence of membership in the Association.

SEC. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

SEC. 4. ACTIVE MEMBERS. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

SEC. 5. ASSOCIATE MEMBERS. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive THE JOURNAL.

SEC. 6. HONORARY MEMBERS. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association

by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

SEC. 7. LIFE MEMBERS. A Life membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

SEC. 8. SCIENTIFIC MEMBERS. Any Negro physician meeting qualifications as set forth in Section 1 may be granted scientific membership by the component county society, upon application, and be awarded the privileges of participation in all scientific sessions. Such members shall pay no dues to the county society or State Association, but may be subject to payment of all dues and assessments of the American Medical Association. Scientific members shall not be entitled to hold office or vote in the county society or the State Association, nor shall they be entitled to Medical Defense.

SEC. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

SEC. 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

SEC. 11. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice or medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

CHAPTER II.

GENERAL MEETINGS

SEC. 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

SEC. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of THE JOURNAL preceding the Annual Session.

SEC. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period not less than five years unless he presents an acceptable excuse.

SEC. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

CHAPTER III.

HOUSE OF DELEGATES

SEC. 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by March 1st of each year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members

of the component society having the vacancy.

SEC. 3. Forty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in Executive Session.

SEC. 4. The House of Delegates shall be presided over by a Speaker, or a Speaker pro tem, whose election shall be the first order of business at the opening session. In the absence of both, a delegate agreeable to it may preside.

SEC. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President.

SEC. 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New Business.

SEC. 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

SEC. 8. All reports and resolutions shall be referred to the appropriate Reference Committees before action is taken by the House of Delegates.

SEC. 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

CHAPTER IV.

COUNCIL

SEC. 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

SEC. 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

SEC. 3. The Council shall set up an Executive Committee, composed of the President, the Secretary-Treasurer, and two members. It shall meet not less often than bi-monthly to review the affairs of the Association. This committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

SEC. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

SEC. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

SEC. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SEC. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties, and whenever practicable, shall attend meetings of the Council, but shall not have a vote except in the absence of his Councilor.

SEC. 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 9. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

SEC. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

SEC. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association, which shall be prepared and presented for its consideration by the Committee on Auditing and Appropriations at the last meeting of the Council in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

SEC. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction, except properly to account in writing for its distribution to the House of Delegates.

SEC. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations

of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Any deficit created on account of the annual session shall be met by the Council on recommendation of the Committee on Auditing and Appropriations.

SEC. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

SEC. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

SEC. 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

SEC. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

SEC. 18. The Council shall have control of all technical exhibits at the annual sessions.

SEC. 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

SEC. 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

CHAPTER V.

ELECTION OF OFFICERS

SEC. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

SEC. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

SEC. 4. Voting shall take place during the hours of the scientific program up to 10:30 A.M. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

SEC. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

CHAPTER VI.

DUTIES OF OFFICERS

SEC. 1. THE PRESIDENT. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and

shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the state during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

SEC. 2. THE PRESIDENT-ELECT. The President-Elect shall be a member of the Council, and shall be a member ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

SEC. 3. THE VICE-PRESIDENTS. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-President will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

SEC. 4. THE SECRETARY-TREASURER. (a) The Secretary-Treasurer shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee an ex-officio member of all committees.

SEC. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

SEC. 4. (c) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between April 1st and March 31st.

CHAPTER VII.

COMPONENT COUNTY SOCIETIES AND DISTRICT SOCIETIES

SEC. 1. COUNTY AND DISTRICT SOCIETIES. All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state, which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

SEC. 2. CHARTER. Upon application to and recommenda-

tion by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

SEC. 3. NAMES OF SOCIETIES. The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

SEC. 4. CUSTODY OF CHARTER. The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

SEC. 5. CONSTITUTIONS AND BY-LAWS. Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

SEC. 6. PURPOSES AND DUTIES. Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 7. OFFICIAL RECORDS. The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been ratified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

SEC. 8. DELEGATES AND ALTERNATES. Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

SEC. 9. COMBINED COUNTIES. The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

SEC. 10. ANNUAL MEETING. Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

SEC. 11. PURPOSES AND DUTIES OF DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the

sub-committees on Legislation and Public Health of the Association.

CHAPTER VIII.

DUES AND ASSESSMENTS

SEC. 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

SEC. 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX.

STANDING COMMITTEES

SEC. 1. The Standing Committees of the Association shall be as follows:

- (a) Committee on Scientific Work
- (b) Committee on Legislation
- (c) Committee on Medical Education and Hospitals
- (d) Committee on Medical Defense
- (e) Committee on Professional Conduct
- (f) Committee on History and Vital Statistics
- (g) Committee on Public Health
- (h) Committee on Maternal Welfare
- (i) Committee on Rural Health
- (j) Committee on Industrial Health
- (k) Committee on Public Relations
- (l) Committee on Cancer
- (m) Committee on Insurance

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required, with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

SEC. 3. THE COMMITTEE ON SCIENTIFIC WORK. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members ap-

pointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in THE JOURNAL of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State. The committee has the authority to make awards for the best scientific exhibits presented each year.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

SEC. 4. THE COMMITTEE ON LEGISLATION. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary.

SEC. 5. THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS. The Committee on Medical Education and Hospitals shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies wherever possible, and shall serve for the Council on Medical Education of the American Medical Association in this State. It shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State, and shall, when indicated, confer with the State Department of Health, the Georgia State Hospital Association and all related organizations and make recommendations to the Association. All problems relating to the postgraduate study of medicine in this State shall be referred to this committee.

SEC. 6. THE COMMITTEE ON MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years each. The duties of this committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided, shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

SEC. 7. THE COMMITTEE ON PROFESSIONAL CONDUCT. The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

SEC. 8. THE COMMITTEE ON HISTORY AND VITAL STATISTICS. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to THE JOURNAL of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of THE JOURNAL and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

SEC. 9. THE COMMITTEE ON PUBLIC HEALTH. The Com-

mittee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The Committee shall also have charge of all matters concerned with medical preparedness and civilian defense in the event of war or other catastrophe. This work will be done in cooperation with national committees set up for the same purpose.

SEC. 10. THE COMMITTEE ON MATERNAL WELFARE shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals. The Director of the Maternal and Child Health Division of the State Department of Public Health shall be a member of the Committee on Maternal Welfare and shall act as its secretary for all purposes of convenience.

SEC. 11. THE COMMITTEE ON RURAL HEALTH shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association, in addition to the Director of the State Department of Public Health who shall be a member ex-officio. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at national conferences on rural health.

SEC. 12. THE COMMITTEE ON INDUSTRIAL HEALTH shall be composed of eight or more members so that there may be one from each of the major industrial areas in the State. The Director of the Industrial Hygiene Division of the State Department of Public Health shall be a member ex-officio. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

SEC. 13. THE COMMITTEE ON PUBLIC RELATIONS shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

SEC. 14. THE COMMITTEE ON CANCER shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

SEC. 15. THE COMMITTEE ON INSURANCE or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

CHAPTER X.

SPECIAL COMMITTEES

Special committees may be created at any time when the necessity arrives. Their necessity must be approved by the Council and they shall be appointed by the President. The following is now authorized:

1. Woman's Auxiliary.

CHAPTER XI.

THE JOURNAL

SEC. 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of THE JOURNAL which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 2. The Council may employ a Business Manager of THE JOURNAL and other personnel and fix the terms of such employment.

SEC. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in THE JOURNAL. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

CHAPTER XII.

RULES AND ETHICS

SEC. 1. The Principles of Ethics of the American Medical Association shall govern the members of this Association.

SEC. 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and By-Laws.

CHAPTER XIII.

AMENDMENTS

These By-Laws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV.

On the adoption of this Constitution and these By-Laws all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

ANNOUNCEMENTS

JANUARY 28: Jefferson County Medical Society will meet at 8:00 p.m. at the Jefferson Hotel, Louisville, Ga.

FEBRUARY 3: Upson County Medical Society is scheduled to meet at 7:30 p.m. at the Upson County Hospital.

FEBRUARY 10: Cobb County Medical Society will meet in the dining room of the Kennestone Hospital, Marietta.

FEBRUARY 10: Colquitt County Medical Society will hold their monthly meeting.

FEBRUARY 10: Spalding County Medical Society is scheduled to hold their monthly meeting.

FEBRUARY 11: Tenth District Medical Society is tentatively scheduled to meet in Augusta.

FEBRUARY 12: Habersham County Medical Society will hold their monthly meeting at 7:30 p.m. at the Commercial Hotel, Cornelia. This will be a combined meeting for dinner with the Medical Auxiliary, followed by separate business meetings.

Doctor C. W. Whitworth, of Gainesville, Georgia, will be the guest speaker for the scientific portion of the program. He will discuss: "Conditions and Treatment of the Nose, Throat and Sinuses, as related to the General Practitioner."

FEBRUARY 22: The Special MAG Conference for Presidents and Secretaries of All District and County Medical Societies will meet at 9:30 a.m., Academy of Medicine, Atlanta.

FEBRUARY 23, 24, 25: Atlanta Graduate Medical Assembly and the Southeastern Section of the American College of Surgeons will meet simultaneously at the Biltmore Hotel, Atlanta. Please make reservations with Mrs. S. R. Roberts, Executive Secretary, Atlanta Graduate Medical Assembly, 15 Peachtree Place, NW, Atlanta.

SOCIETIES

Sixth District Medical Society elected the following officers at their recent meeting in December. President, Dr. William Rawlings, Sandersville; Vice-President, Dr. Tom Ross, Macon; Secretary, Dr. C. H. Richardson, Jr., Macon; Councillor, Dr. H. D. Allen, Jr., Milledgeville; Vice-Councillor, Dr. H. G. Weaver, Macon. Members appointed to serve on the MAG Committee on Legislation—Dr. Henry Tift and the MAG Sub-Committee on Public Health—Dr. W. D. Hazelhurst.

Bibb County Medical Society, at their December 2 meeting elected Dr. Ralph Newton, President; Dr. Milford Hatcher, President-Elect; and Dr. Henry Tift, Secretary-Treasurer.

DeKalb County Medical Society installed their new officers at their meeting December 8. Elected as

President was Dr. W. Pat Smith; President-Elect, Dr. W. A. Mendenhall; and Secretary-Treasurer, Dr. Chester Morse. Dr. Freeman Simmons was elected program chairman.

Dougherty County Medical Society elected the following officers at a meeting December 9. Dr. Robert Dunn, President; Dr. N. R. Thomas, President-Elect; Dr. William Fields, Vice-President; and Dr. Paul Russell, Secretary-Treasurer.

Fulton County Medical Society, at their meeting December 18, elected Dr. John W. Turner, President-Elect; Dr. Duncan Shepard, Vice-President; Dr. Carter Smith, Trustee; Dr. Lester Rumble, Jr., Trustee (junior member); and Dr. C. Purcell Roberts, Dr. Charles F. Stone, Dr. J. Harry Rogers, Delegates and Alternates. Dr. William G. Hamm, 1952 President-Elect, was installed as President.

Habersham County Medical Society elected new officers at their last meeting December 11. They are

as follows: President, Dr. C. M. Henry; Vice-President, Dr. George Tolhurst; Secretary, Dr. L. G. Hicks; Delegate, Dr. J. J. Arrendale; Alternate Delegate, Dr. C. M. Henry; Censors, Drs. B. J. Roberts, F. O. Garrison, A. J. Walter; and Public Relations Officer, Dr. J. L. Walker.

Georgia Medical Society installed Dr. Howard J. Morrison, 1952 President-Elect, who will succeed Dr. J. H. Pinholster as President for the coming year. Dr. L. M. Freedman was named President-Elect for 1953. Other officers elected who will serve with Dr. Morrison were Dr. R. B. Brown, Vice-President and Dr. William W. Osborne, Secretary-Treasurer.

Laurens County Medical Society heard Dr. Henry H. Tift, Macon, as their guest speaker at their December meeting. Dr. Robert T. Anderson was elected President, with Dr. C. G. Moye as Vice-President. Dr. Nell Kinney was elected Secretary-Treasurer.

Tri-County Medical Society held its final meeting of the year in November at the Woman's Club in Blakely. Elected to serve for 1953 were: President, Dr. T. W. Rentz, Colquitt; Vice-President, Dr. J. G. Standifer, Blakely; Secretary-Treasurer, Dr. T. H. Lamson, Arlington; Delegate, Dr. R. B. Quattlebaum, Ft. Gaines; and on the Board of Censors, Drs. S. P. Holland (1953), W. C. Baxley (1954) and J. W. Merritt (1955). The meeting date has been changed from the Third Thursday to the Second Wednesday of each month.

Ware County Medical Society met December 3 and elected as President Dr. Arthur Knight, Jr. Officers elected to serve with Dr. Knight were Dr. Clayton M. Massey, Vice-President; Dr. T. J. Ferrell, Secretary-Treasurer; Drs. W. Loomis Pomeroy and Leo Smith, MAG House of Delegates with Drs. Ansley Seaman and Vilda Schuman as Alternates. Dr. Ansley Seaman and Dr. Katherine Hendry were elected to the Board of Censors.

DEATHS

CHAPMAN: *Dr. William Allen Chapman*, 87, of Cedartown, died at his home after a brief illness November 30. A graduate of the University of Maryland Medical School, class of 1887, Dr. Chapman began his practice in Cedartown in 1889.

HATTAWAY: *Dr. John Calvin Hattaway, Jr.*, 52, of Edison, died November 29 after an illness of several months. Dr. Hattaway had practiced in

Edison since his graduation from Emory University School of Medicine in 1926.

HUNT: *Dr. G. C. D. Hunt*, 82, of Cordele, died November 27. Dr. Hunt, a pioneer Cordele physician, was a graduate of Emory University School of Medicine, 1896.

SAGGUS: *Dr. John Gordon Saggus*, 64, of Harlem, died in the University Hospital, Augusta, November 24. Dr. Saggus had been in poor health for several months. A graduate of Emory University School of Medicine, 1912, Dr. Saggus began his practice in Wilkes County and moved to Harlem in 1921.

PERSONALS

Drs. Eustace A. Allen, Atlanta; *Charles H. Richardson*, Macon; *William E. Barfield* and *Richard J. Wens*, both of Augusta; and *James B. Kay*, Byron, were listed on the official registration of physicians, Sixth Annual Clinical Session of the American Medical Association, Denver, December 2-5.

Dr. Ella Andrews, Tifton, spoke to the Tifton Rotary Club at their November meeting. Dr. Andrews, a member of the Tifton Pilot Club, described the aims and organization of the Pilot Club.

Dr. William E. Barfield, Savannah, gave an address on the "Potential Capabilities of Atomic Warfare" before the Savannah Rotary Club recently.

Dr. Robert J. Black, Rome, was recently certified by the American Academy of Pediatrics.

Dr. F. Phinizy Calhoun, Jr., of Atlanta, addressed the Greenville (S. C.) County Medical Society on "The Responsibilities of the Ophthalmologist in General Medical Practice" on November 4. Dr. Calhoun also spoke to the St. Louis Ophthalmological Society December 4. His subject was "The Clinical Recognition of Epithelization of the Anterior Chamber Following Cataract Extraction."

Dr. Howard Clifton Derrick was recently cited by the *Montezuma Citizen and Georgian* for his 50 years of service to the community of Oglethorpe.

Dr. John A. Duncan, of Cordele, spoke to the Cordele Lions Club on the subject of "Socialized Medicine." Dr. Duncan also addressed a group of journalists at the Third Newspaper District meeting. His topic covered Socialized Medicine and his experiences in medicine in Britain.

Drs. G. A. Duncan, *Floyd Sanders* and *Howard Lee* opened their new offices at 603 Church Street,

Decatur on November 1. Their new quarters were designed by R. S. Monday, chief architect of the Mion Construction Co., Atlanta.

Dr. Edgar M. Dunstan, of Atlanta, has been appointed a consultant to the Council on National Emergency Medical Service of the American Medical Association.

Dr. Wilbur L. Flesch, of Rochester, N. Y., is now associated with Dr. W. F. Reavis and Dr. Lovick W. Pierce in the practice of urology and urologic surgery in the Bunn Building, Waycross.

Drs. Robert B. Greenblatt, Ralph H. Chaney and S. L. Clark, all of Augusta, collaborated on the lead article in the December *GP*, entitled "Diagnosis and Management of Cushing's Syndrome."

Dr. S. L. Harp, formerly of Cochran, has opened offices for the practice of general medicine in the Terrell Building, Toccoa.

Dr. Howard J. Morrison told members of the Savannah Society of Obstetricians and Pediatricians that European medicine is not lagging behind American practice in an address to this group recently.

Dr. J. C. Patterson, of Cuthbert, recently spoke to the Cuthbert Lions Club on the subject "The History of Medicine." The meeting was held at Andrews College.

Dr. David Henry Poer, Atlanta, was recently appointed to the Advisory Committee of the newly ac-

tivated chapter of the Student American Medical Association at the Medical College of Georgia. Other members of the Committee include *Drs. G. Lombard Kelly, Lester Bowles, Harry B. O'Rear and Harry Harper*.

Fishing companions of the late *Dr. Antonio J. Waring* recently dedicated a bronze plaque on a freshly planted oak tree in Forsyth Park, Savannah, in memory of Dr. Waring.

Dr. Edna Smith Porth, of Atlanta, announces the opening of offices at 245 East Paces Ferry Road, N. E., Atlanta, for the practice of general medicine.

Dr. Fincher Powell, of Decatur, has been recalled to active duty with the U. S. Navy and is stationed at Camp LeJeune, N. C.

Dr. W. C. Waugh, of Nashville, is now residing and practicing in Dunnellon, Florida.

Dr. Floyd R. Sanders, of Decatur, has been recalled to active duty with the U. S. Navy. He reported to duty at the U. S. Naval Shipyards, Charleston, S. C., January 7. Dr. Sanders new address is Box 198, Isle of Palms, S. C.

Dr. Carl A. Whitaker, chairman of the Psychiatry Department at Emory University School of Medicine, outlined the role of the mental health clinic in an address to the Chatham-Savannah Mental Health Association meeting at the DeSoto Hotel, Savannah, recently.

AUXILIARY

DeKalb County Medical Society Auxiliary met December 8 at Rich's "Little Auditorium" where the department store entertained the group with an interesting demonstration of new ideas in Christmas wrapping and decorating. A combined business and social hour closed the meeting.

Fulton County Medical Society Auxiliary featured

at their December meeting the celebration of birthdays of each individual member. At the meeting preceding the luncheon, Mrs. Gus Elliott, of Cuthbert, presented the Auxiliary a prize for the best observance of Doctor's Day in the 17 states that comprise the Southern Medical Association.

Ware County Medical Society Auxiliary members were entertained at their December meeting at a luncheon given by Mrs. W. F. Reavis and Mrs. Lovick Pierce at the Ware Hotel.

MISCELLANY

At the regular monthly meeting of the staff of the Macon Hospital, December 16, the following new officers were elected: President, Dr. J. C. Anderson; Vice-President, Dr. Ralph Newton; Chief of Staff, Dr. Willard Golsan; and Assistant Chief of Staff, Dr. W. D. Hazelhurst.

A portrait of the late Dr. John Turner McCall, founder of the McCall Hospital, Rome, was unveiled December 11 by his granddaughter Anne Turner McCall at a brief ceremony in the hospital.

Dr. Robert C. Major, professor of thoracic surgery at the Medical College of Georgia spoke on "Chest Surgery Through the Past 20 Years" at a meeting of the Woman's Board to the University Hospital held at the Doughty Nurses Home.

To clarify present status, while Dr. Robert C. Major is Chairman of the Department of Surgery, Medical College of Georgia, this in no way affects his position as Head of the Department of Thoracic Surgery and his activities in that field.

Dr. Jack Sherman is associated with the Department of Surgery as a liaison teacher in General Surgery on a part-time basis at the Medical College of Georgia.

Medical Association of Georgia

ROSTER *of* MEMBERSHIP

December 31, 1952

This roster is made up of physicians whose names have been forwarded the Headquarters office by the secretaries of the component county societies and whose dues have been paid as of December 31, 1952. Also included are the names of those physicians who have been classified as Associate, Life and Scientific members. For any omissions, check with the county society secretary.

This official roster of members will be used as a basis of determination of the number of delegates and alternates to serve in the House of Delegates at the Annual Session to be held in Savannah, DeSoto Hotel, May 10-13, 1953. (One delegate for each 25 members or fraction thereof—see new By-Laws.)

Members of county societies having less than three members are listed temporarily as Members at Large, until they have been accepted by an adjacent county society. (See new By-laws.)

APPLING COUNTY

Bedingfield, J. A., Baxley
Branch, W. D., Baxley
Brown, J. B., Jr., Baxley
Holt, J. T., Baxley
Kennedy, F. D., Baxley
McCrackin, H. C., Baxley
Ohlmacher, A. P., Baxley

BALDWIN COUNTY

Allen, E. W., Milledgeville
Allen, H. D., Jr., Milledgeville
Baugh, J. E., Milledgeville
Bailey, L. A., Milledgeville
Binion, Richard (Life), Milledgeville
Bradford, R. W., Milledgeville
Cary, H. R., Milledgeville
Chesnutt, T. H., Milledgeville
Clodfelter, T. C., Milledgeville
Combs, J. D., Milledgeville
Echols, G. L., Milledgeville
Fulghum, C. B., Milledgeville
Gibson, W. M., Milledgeville
Giles, B. J., Milledgeville
Jones, J. R., Jr., Milledgeville
Peacock, T. G., Milledgeville

Pennington, L. E., Terrell State Hospital, Terrell, Texas
Pennington, V. M., Terrell State Hospital, Terrell, Texas
Pursley, N. B., Georgia Training School, Gracewood
Sikes, W. A., Raleigh State Hospital, Raleigh, N. C.
Smith, M. E., Milledgeville
Walker, E. Y., Milledgeville
Waller, Robt. D., Milledgeville
Wiley, J. D., Milledgeville
Williams, D. C., Milledgeville
Woods, O. C., Milledgeville
Yarbrough, Y. H., Milledgeville

BARTOW COUNTY

Bradford, H. B., Cartersville
Dillard, W. B., Jr., Cartersville
Horton, A. L., Cartersville
Howell, S. M., Cartersville
Howell, W. H., 1st Lt. (Asso.), (In Military Service)
McGowan, H. S., Cartersville
Quillian, W. B., Jr., Cartersville
Stanford, J. W., Cartersville
Whately, L. R., Cartersville
Wofford, W. E., Cartersville

BEN HILL COUNTY

Coffee, W. P., Fitzgerald
Cornwell, G. K., Fitzgerald
Dismuke, H. L., Ocilla
Harper, A. (Life), Wray
Johnson, R. J., Jr., Fitzgerald
McElroy, S. L. (Life), Ocilla
McMillan, J. E., Fitzgerald
Sams, W. C., Jr., Ocilla
Smith, J. E., Fitzgerald
Ward, F. O., Fitzgerald
Ware, D. B., Fitzgerald
Willcox, W. D., Fitzgerald
Willis, G. W., Ocilla

BIBB COUNTY

Aldrich, F. N., Professional Building, Macon
Anderson, C. L., 556 Mulberry St., Macon
Anderson, J. C., 106 Stanislaus Circle, Macon

Applewhite, J. D., 700 Spring Street, Macon
Atkinson, H. C., 700 Spring St., Macon
Barnes, W. P., Jr., 787 Spring Street, Macon
Barton, W. L., Persons Bldg., Macon
Baxley, W. W., Persons Bldg., Macon
Bazemore, W. L., 553 Walnut Street, Macon
Benton, C. C., 781 Spring St., Macon
Billinghurst, G. A., Persons Bldg., Macon
Birdson, W. R., 531 North Ave., Macon
Blum, L. J., Jr., Warner Robins
Boswell, W. C., Persons Bldg., Macon
Brannen, E. A., 700 Spring St., Macon
Brown, R. A., Medical Arts Bldg., Macon
Bush, W. H., 959 Daisy Park, Macon
Caldwell, J. L., 781 Spring St., Macon
Cary, R. F., 845 Hemlock St., Macon
Chrisman, W. W., 700 Spring Street, Macon
Clay, J. E., 557 Walnut St., Macon
Cole, A. A., 810 Mulberry St., Macon
Corn, Ernest, 700 Spring St., Macon
Daniel, J. W., Jr., Bibb Bldg., Macon
Davenport, L. F., 700 Spring St., Macon
Dove, W. B. (Life), 135 Boulevard, Macon
DuPree, G. W., Gordon
DuPree, J. T., Professional Bldg., Macon
Eberhart, R. C., 3671 Houston Ave., Macon
Edenfield, R. W., 700 Spring St., Macon
Farmer, C. H., 553 Walnut St., Macon
Ferrell, R. G., Jr., Professional Bldg., Macon
Forester, B. W., 700 Spring St., Macon
Fry, E. L., 781 Spring St., Macon
Gallemore, J. L., Perry
Goldstein, J. J., Warner Robins
Golsan, W. R., Persons Bldg., Macon
Goodman, L. J., Bibb Bldg., Macon
Goolsby, R. C., Jr., 700 Spring St., Macon
Greer, Z. E., Bibb Co. Health Dept., Macon
Hall, J. I., Bankers Ins. Bldg., Macon
Hanson, J. F., 3834 The Prado, Macon

Harrold, Thos., 700 Spring St., Macon
Hatcher, M. B., 781 Spring St., Macon
Hazlehurst, W. D., 765 Spring Street, Macon
Hicks, W. L., 3671 Houston Avenue, Macon
Hogan, J. T., Jr., 3828 The Prado, Macon
Holden, W. H., 367 New St., Macon
Hooper, R. J. Professional Bldg., Macon
Houser, F. M., Grand Bldg., Macon
James, L. P., 700 Spring St., Macon
Johnson, J. F., 1445 Oglethorpe Street, Macon
Jones, J. P., 865 Hemlock St., Macon
Jones, R. W., Jr., 959 Daisy Park, Macon
Jordan, W. K., 700 Spring St., Macon
Kay, J. B., Byron
Keen, O. F., Persons Bldg., Macon
King, J. L., Persons Bldg., Macon
King, J. L., Jr., Persons Bldg., Macon
Lewis, W. E., Persons Bldg., Macon
Mass, Max, Macon Hospital, Macon
Massenburg, C. Y., 557 Walnut Street, Macon
Mays, J. R. S., 700 Spring St., Macon
McAllister, R. W. (Asso.), 700 Spring Street, Macon
McFarlane, J. W., 201 Professional Bldg., Macon
McLaughlin, C. K., 703 Bankers Ins. Bldg., Macon
McMichael, V. H., Clinic Hospital, Macon
McMillan, E. C., Jr., 219 Bibb Bldg., Macon
Meriwether, W. W., 369 Cotton Ave., Macon
Meserve, F. B., 721 McArthur Bld., Warner Robins
Mobley, W. E. (Life), 563 College St., Macon
Nathan, D. E., Fort Valley
Neal, J. C., Jr., 203 Professional Bldg., Macon
Neuberg, S. C., 608 Persons Bldg., Macon
Newman, W. A., 700 Spring St., Macon
Newton, R. G., Persons Bldg., Macon
Glnick, Herbert M., 700 Spring St., Macon
Orr, W. W., 700 Spring St., Macon
Patton, S. E., 797 Spring St., Macon
Phillips, A. M., 1113 Bankers Ins. Bldg., Macon
Pope, E. M., 700 Spring St., Macon
Porch, L. D., 700 Spring St., Macon
Rawls, L. L., Persons Bldg., Macon
Reifler, R. M., 729 Pine St., Macon
Richardson, C. H., 700 Spring Street, Macon
Richardson, C. H., Jr., 700 Spring St., Macon
Richardson, R. W., 1429 Oglethorpe Ave., Macon
Ridley, C. L., Macon Hospital, Macon
Ridley, C. L., Jr., Persons Bldg., Macon
Rogers, T. E. (Life), 120 Clisby Place, Macon
Rogers, T. E., Jr., 700 Spring Street, Macon
Ross, T. L., Jr., 700 Spring St., Macon
Rubin, S. N., Grand Bldg., Gordon
Rumble, C. T., 700 Spring St., Macon
Rutland, S. C., Ga. Dept. of Public Health, Atlanta

Siegel, A. E., 553 Walnut St., Macon
Smith, H. D., VA Hospital, Long Beach, Calif.
Smith, J. A., 700 Spring St., Macon
Stamps, E. R., 613-617 Bibb Bldg., Macon
Stewart, J. B., 700 Spring St., Macon
Suarez, Raymond, 553 Walnut Street, Macon
Swilling, Evelyn, 553 Walnut St., Macon
Thompson, O. R., 700 Spring St., Macon
Tift, Henry H., 765 Spring St., Macon
Vinson, Frank, Fort Valley
Walker, D. D., 700 Spring St., Macon
Walker, D., Jr., 753 Pine St., Macon
Ware, Ford, 607 Bankers Ins. Bldg., Macon
Wasden, C. N., Bankers Ins. Bldg., Macon
Watson, E. R., 553 Walnut St., Macon
Weaver, H. G., 700 Spring St., Macon
Weems, H. E., Jr., Perry
Williams, W. A., 700 Spring St., Macon
Woodhall, J. P., 700 Spring St., Macon
Work, S. D., Jr., 729 Pine St., Macon
Zachary, J. D., Gray

BLUE RIDGE COUNTY

Brooks, C. C., Blue Ridge
Burns, R. A., Blue Ridge
Edge, H. M., Blairsville
Hicks, T. J., McCaysville
May, L. C., Blue Ridge
O'Daniel, J. F., Macon City Hospital, Macon
O'Daniel, John, Ellijay
Shingleton, G. C., Blue Ridge
Tanner, W. F., Young Harris
Watkins, E. W., Ellijay

BROOKS COUNTY

Jones, A. B., Jr., Quitman
Smith, L. A., Quitman
Thwaite, W. G., Quitman
Wasden, H. A., Quitman

BULLOCH-CANDLER-EVANS COUNTIES

Barksdale, J. H., Jr., Statesboro
Daniel, A. B., Statesboro
Daniel, J. W., Claxton
Deai, A. M., Statesboro
Deal, B. A., Statesboro (deceased)
Deal, Helen Read, Statesboro
Deal, J. D., Portal
Floyd, W. E., Statesboro
Griffin, L. H., Claxton
Hames, C. G., Claxton
Kennedy, R. L., Metter
Lovett, L. F., Metter
McElveen, J. M., Brooklet
Mooney, John, Jr., Statesboro
Moore, E. L., Statesboro
Nevil, J. L., Metter
Neville, J. C. (Life), Register
Olliff, H. H., Register
Patrick, J. Z. (Life), Pulaski
Simmons, W. E., Metter
Stapleton, C. E., Statesboro
Whiteside, J. H., Statesboro

BURKE COUNTY

Barger, E. A., Waynesboro
Bent, H. F., Midville
Butterfield, D. L., Waynesboro
Byne, J. M., Jr., Waynesboro
Cantrell, J. E., Midville

Green, C. G., Waynesboro
Hillis, W. W., Sardis
McCarver, W. C., Vidette
Thompson, Cleveland, Waynesboro
Thompson, Cleveland, Jr., Waynesboro

CARROLL COUNTY

Aderhold, W. A., Carrollton
Allen, C. H., Bremen
Bagley, D. A. (Asso.), Austell
Barker, H. L., Carrollton
Bass, E. C., Carrollton
Berry, R. L., Villa Rica
Brock, W. B. (Life), 500 Majorea Ave., Coral Gables, Fla.
Cauthen, L. R., Buchanan
Denney, R. L., Carrollton
Downey, W. P., Tallapoosa
Eaves, B. F. (Life), Draketown
Hamilton, R. E., Douglasville
Hogue, W. L., Villa Rica
Holtz, Louis, P. O. Box 265, Carrollton
King, O. D., Bremen
Morgan, F. W., Douglasville
Nutt, J. J., Bowdon
Parks, F. M., 144 Dixie St., Carrollton
Patrick, E. V., Carrollton
Powell, B. C. (Life), Villa Rica
Powell, J. E., Villa Rica
Powell, J. E., Jr., Villa Rica
Pritchett, J. H., Jr., Bremen
Reese, D. S., Carrollton
Reeve, T. E., Jr., Carrollton
Roberts, O. W., Carrollton
Smith, W. P. (Life), Bowdon
Taylor, T. B., Douglasville
Thomasson, W. E., Carrollton
Vansant, C. V., Jr., Douglasville
Vansant, C. V., Douglasville
Watts, J. W., Bowdon
Wilson, L. E., Bowdon
Word, J. J., Tallapoosa
Worthy, W. S., Carrollton

CHATHAM COUNTY

Barfield, W. E., 722 Drayton Street, Savannah
Bedingfield, W. C., 14 West Hull St., Savannah
Bowden, R. O., 24 W. Gaston Street, Savannah
Brawner, D. L., 513 Whitaker Street, Savannah
Broderick, J. R., 125 E. Jones Street, Savannah
Brown, C. T., Guyton
Brown, F. B., 22 W. Gaston Street, Savannah
Brown, W. E., 14 W. Hull Street, Savannah
Center, A. H., 17-A W. Gordon Street, Savannah
Charlton, T. J. (Life), 220 E. Oglethorpe Ave., Savannah
Chisholm, J. F., 512 Abercorn S treet, Savannah
Cirinione, V. J., 1 West Duffy Street, Savannah
Clary, W. U., 513 Whitaker Street, Savannah
Cole, W. A., 32 East Taylor Street, Savannah
Coward, A. W., 17 E. Jones Street, Savannah
Craig, J. B., 19½ W. Gordon Street, Savannah
Crawford, W. B., 14 E. Taylor Street, Savannah

Crawford, W. B., Jr., 14 E. Taylor St., Savannah
 Dancy, W. R., 102 W. Jones Street, Savannah
 Daniel, J. W. (Life), 26 East 31st St., Savannah
 Daniel, J. W., Jr., 5 East Jones Street, Savannah
 deCaradeuc, St., J. R., DeRenne Apts., Savannah
 Demmond, E. C., DeRenne Apts., Savannah
 Drane, Robt., DeRenne Apts., Savannah
 Duncan, J. Harry, 116 E. Jones Street, Savannah
 Dunn, L. B., 220 E. Huntington Street, Savannah
 Edwards, D. B. (Life), Ellabell
 Edwards, E. G., 3½ E. Gordon Street, Savannah
 Egan, M. J., 210 E. Liberty Street, Savannah
 Elliott, J. L., 212 E. Huntington St., Savannah
 Epting, M. J., 722 Drayton Street, Savannah
 Faggart, G. H., 18 W. Oglethorpe Ave., Savannah
 Fillingim, D. B., 449 Abercorn Street, Savannah
 Fleming, P. M., 14 W. Taylor Street, Savannah
 Freedman, L. M., 1½ E. Gordon Street, Savannah
 Freeman, T. R., 513 Whitaker Street, Savannah
 Fulmer, W. H., 19 E. 34th Street, Savannah
 Gleaton, E. N., 2 East Jones Street, Savannah
 Goldenstar, G. W., 106 East Jones St., Savannah
 Gottschalk, R. B., 123 E. Jones Street, Savannah
 Graham, R. E., 212 E. Goston Street, Savannah
 Ham, O. E., 414 Bull Street, Savannah
 Henderson, C. A., 25 E. Charlton St., Savannah
 Hoffman, Frank, Savannah
 Holton, C. F., DeRenne Apts., Savannah
 Hopkins, Anne, 22 E. Jones Etreet, Savannah
 Howard, Lec, DeRenne Apts., Savannah
 Howard, Lee, Jr., DeRenne Apartments, Savannah
 Hawkins, J. W., 111 East Jones St., Savannah
 Johnson, G. H., Jr., 126 E. Oglethorpe Avenue, Savannah
 Jones, Jabez, 11 W. Gordon Street, Savannah
 Kandel, H. M., 432 Abercorn Street, Savannah
 Kanter, W. W., 345 Bull St., Savannah
 Kelley, A. J., 4 Taylor St., Savannah
 King, Ruskin, 10 W. Taylor Street, Savannah
 Lang, G. H., 202 East Liberty Street, Savannah
 Lange, S. J., 12 East Taylor Street, Savannah
 Lawless, T. F., 204 E. Liberty Street, Savannah
 Lee, Lawrence, Jr., 113 E. Gwinnett Street, Savannah

Levington, H. L., 209 E. Gaston Street, Savannah
 Lippitt, W. H., 224 E. Huntington St., Savannah
 Long, W. V., Hotel DeSoto, Savannah
 Lott, O. H., 111 E. Jones St., Savannah
 Lynn, S. C., 124 E. Jones St., Savannah
 Maholick, L. T., 20 W. Baston Street, Savannah
 Maner, E. N. (Life), 101 East 45th St., Savannah
 Marsh, P. R., DeRenne Apartments, Savannah
 Martin, R. V. (Life), 18 E. 31st St., Savannah
 Mazo, M. M., 8 E. Taylor St., Savannah
 McGee, H. H., 7 W. Gordon Street, Savannah (deceased)
 McGoldrick, T. A., Jr., 15 E. Gordon Street, Savannah
 McLean, Jay, 612 Drayton Street, Savannah
 Metts, J. C., 427 Bull Street, Savannah
 Morrison, H. J., 444 Drayton Street, Savannah
 Nichols, F. T., Jr., 123 E. 51st St., Savannah
 Oliver, R. L., DeRenne Apartments, Savannah
 Olmstead, G. T., 20 E. Taylor Street, Savannah
 O'Neill, J. C., 202 E. Liberty Street, Savannah
 Orteaga, Paul, Jr. (Asso.), U. S. Communicable Disease Center, Savannah
 Osborne, E. S., 19 E. Jones Street, Savannah
 Osteen, W. L., 610 Anderson Avenue, Savannah
 Pacifici, Joseph, 2 E. Taylor Street, Savannah
 Peterson, T. A., 11 West Jones Street, Savannah
 Pinholster, J. H., 241 Abercorn Street, Savannah
 Porter, J. E., 128 E. Taylor Street, Savannah
 Portman, H. J., 9 E. Gordon Street, Powers, L. K., 29 E. Jones St., Savannah
 Prince, C. L., 2515 Habersham Street, Savannah
 Puckett, H. E., 118 East Hall Street, Savannah
 Quattlebaum, J. K., 24 E. Gaston St., Savannah
 Rabhan, L. J., 314 E. Gaston Street, Savannah
 Redmond, C. G., 701 Whitaker Street, Savannah
 Redmond, C. R. A., 530 E. 49th Street, Savannah
 Righton, H. Y., 101 E. Waldberg Street, Savannah
 Robinson, David, P. O. Box 394, Savannah
 Rosen, E. F., 5 East Gordon Street, Savannah
 Rosen, S. F., 4 East Jones St., Savannah
 Rubin, Jacob, 350 Bull St., Savannah
 Salter, W. L., 2427 Abercorn Street, Savannah
 Sax, C. E., 214 E. Gaston St., Savannah
 Scardino, P. L., 2515 Habersham Street, Savannah
 Schley, R. L., Jr., 114 W. Goston Street, Savannah
 Schneider, M. M., 126 Gaston Street, Savannah

Sharpley, Helen, 1017 Abercorn Street, Savannah
 Sharpley, H. F., Jr., DeRenne Apts., Savannah
 Sharpley, J. G., DeRenne Apartments, Savannah
 Shearouse, J. W., 13 East Taylor Street, Savannah
 Shepherd, E. C., Savannah
 Smith, H. M., 9 West Gordon Street, Savannah
 Smith, P. H., 3 East Gordon Street, Savannah
 Stalvey, J. K., Jr., 114 E. Jones Street, Savannah
 Straight, G. W., 202 E. Gordon Street, Savannah
 Train, J. K. (Life), 1107 Bull Street, Savannah
 Train, J. K., Jr., 1107 Bull Street, Savannah
 Taylor, L. B. (Life), 601 Whitaker St., Savannah
 Upson, E. T., 201 E. Hall St., Savannah
 Usher, Chas., 6 E. Liberty St., Savannah
 Victor, Irving, 228 E. Huntington St., Savannah
 Victor, Jules, Jr., 126 E. Taylor Street, Savannah
 Waring, A. J., Jr., DeRenne Apts., Savannah
 Waring, Ruth M., 905 East Duffy St., Savannah
 Waring, T. P., 905 Duffy St., Savannah
 Westerfield, C. W., 101 Garrard Ave., Savannah
 Whelan, E. J., 14 W. Jones Street, Savannah
 Williams, A. F., 127 Gordon Street, Savannah
 Williams, L. W., 105 East Jones Street, Savannah
 Wilson, W. D., 104 W. Waldberg St., Savannah
 Winburn, J. R., Jr., DeRenne Apts., Savannah
 Withington, J. C., 106 W. Jones Street, Savannah
 Youngblood, S., Jr., 108 E. Taylor St., Savannah
 Zigler, Isaac M. (Asso.), U. S. Public Health Service, Savannah
 Zirkle, J. G., 722 Drayton Street, Savannah

CHATTOOGA COUNTY

Allen, J. J., Trion
 Gist, W. T., Summerville
 Goodwin, H. A., Jr., Summerville
 Hair, W. B., Summerville (deceased)
 Hyden, W. U., Trion
 Little, G. H., Trion
 Little, R. N., Summerville

CHEROKEE-PICKENS COUNTIES

Andrews, C. R., Jr., Canton
 Coker, G. N., Canton
 Hendrix, A. M., Canton
 Hendrix, M. G. (Life), Ball Ground
 Jones, R. T., III, Canton
 Looper, B. K., Canton
 Moore, R. M. (Life), Waleska
 Parrow, G. H., Jasper
 Roper, C. J., Jasper
 Roper, E. A., Jasper
 Vansant, T. J. (Life), Woodstock

CLARKE-MADISON-OCONEE COUNTIES

Barner, J. L., Athens General Hospital,
Athens
Bond, D. T., Danielsville
Bonner, W. H., 130 W. Hancock Ave.,
Athens
Boyd, A. B., Athens General Hospital,
Athens
Brown, W. W., City Health Dept.,
Athens
Bryant, C. H., Comer
Byrd, H. G., 1010 Prince Ave., Athens
Cabaniss, W. H., Sou. Mutual Bldg.,
Athens
Dover, T. A., 1010 Prince Ave., Athens
Erwin, G. Y., 1010 Prince Ave., Athens
Florence, Loree, Sou. Mutual Bldg.,
Athens
Gallis, A. H., Georgian Hotel, Athens
Gerdine, L., Sou. Mutual Bldg., Athens
Goldsmith, L. H., Sou. Mutual Bldg.,
Athens
Green, J. A., 1010 Prince Ave., Athens
Gustin, R. M., 530 Holman Avenue,
Athens
Harris, H. B., 1010 Prince Ave., Athens
Harrison, W. B., State Health Dept.,
Athens
Holliday, H. C., Sou. Mutual Bldg.,
Athens
Hubert, M. A., 1010 Prince Avenue,
Athens
Hunnicut, J. A., Sou. Mutual Bldg.,
Athens
Keller, A. P., Jr., 1010 Prince Avenue,
Athens
Kitchens, W. C., 130 W. Hancock Ave.,
Athens
McPherson, J. H. T., Jr., 1010 Prince
Avenue, Athens
Meissner, Tom, 1010 Prince Avenue,
Athens
Middlebrooks, C. O. (Life), Holman
Hotel, Athens
Moss, W. L. (Life), Jefferson Road,
Athens
Mullins, D. F., Jr., St. Mary's Hosp.,
Athens
Neighbors, J. B., Jr., 1010 Prince Ave.,
Athens
Patton, L. S., 721 Sou. Mutual Bldg.,
Athens
Randolph, R. H., 130 W. Hancock Ave.,
Athens
Simpson, J. A., 1010 Prince Avenue,
Athens
Stegeman, J. F., 1010 Prince Avenue,
Athens
Talmadge, H. E., Sou. Mutual Bldg.,
Athens
Talmadge, S. M., 1010 Prince Avenue,
Athens
Traylor, J. B., 455 N. Milledge Avenue,
Athens
Veale, E. O., Arnoldsville
Wenzel, R. E., University of Georgia,
Athens
Westbrook, R. J. (Life), Ila
Whelchel, G. O., Sou. Mutual Bldg.,
Athens
Whitley, L. L., 234 College Ave., Athens

CLAYTON-FAYETTE COUNTIES

Bussey, T. J., Fayetteville
Campbell, R. P., Cedartown
Coleman, Y. R., Jonesboro
Robak, J. L., Miami, Fla.

Sams, F. A., Jr., Fayetteville
Sams, Helen F., Fayetteville
Wallis, J. R., Lovejoy

COBB COUNTY

Bannister, C. D., Marietta
Benson, E. B., 304 Cherokee Street,
Marietta
Benson, W. H., Jr., 213 Cherokee Street,
Marietta
Burleigh, B. D., 515 Clay St., Marietta
Busch, J. F., Jr., 310 McDonald Street,
Marietta
Bussey, J. G., Austell
Butner, J. H., Powder Springs
Caulbe, Geo., Acworth
Clark, F. B., Austell
Clark, R. Y., Jr., 206 Roswell Street,
Marietta
Colquitt, A. O., Jr., 215 Cherokee St.,
Marietta
Colquitt, H. S., Smyrna
Crawley, W. G., 1505 Roswell Street,
Marietta
Fowler, A. H., Marietta Hospital Bldg.,
Marietta
Fowler, R. W., Marietta Hospital Bldg.,
Marietta
Garland, C. M., Jr., Smyrna
Garrett, L. G., Jr., Austell
Gober, W. M., 304 Cherokee Street,
Marietta
Hagood, G. F., Marietta Hospital Bldg.,
Marietta
Hagood, M. M., Marietta Hosp. Bldg.,
Marietta
Inglis, E. P., Jr., 1607 Roswell Street,
Marietta
Lester, J. E., 208 S. Waddell Street,
Marietta
Levy, M. S., Smyrna
Lindley, F. P., Powder Springs
Marks, E. S., 261½ N. Park Square,
Marietta
McCall, M. N., Jr., Acworth
Mitchell, W. C., Smyrna
Musarra, E. A., 220 Church Street,
Marietta
Perkinson, W. H., Marietta Hospital
Building, Marietta
Schmidt, F. K., 206 Roswell Street,
Marietta
Teem, M. V. B., 502 Cherokee Street,
Marietta
Vansant, T. J., Jr., 105 Seminole Drive,
Marietta

COFFEE COUNTY

Bell, E. D., Douglas
Clark, T. H. (Life), Douglas
Goodwin, H. J., Douglas
Harper, Sage, Douglas
Jardine, D. A., Douglas
Johnson, R. L., Douglas
Joiner, H. G., Douglas
Meeks, C. S., Jr. (Asso.), Hunter Field,
Savannah
Parker, T. L., Douglas
Oliver, J. A., Douglas
Quillian, B. O., Douglas
Shellhouse, L. H., Willacoochee
Wallace, J. W., Douglas

COLQUITT COUNTY

Brannen, C. N., Moultrie
Conger, P. D., Moultrie
Fike, R. H., Moultrie
Fokes, R. E., Jr., Moultrie

Funderburk, A. G., Moultrie
Gay, F. M., Moultrie
Holmes, E. C., Moultrie
Hutchinson, N. H., Moultrie
Joiner, R. M., Moultrie
Lanier, J. E. (Life), Moultrie
McCoy, J. F., Moultrie
McGinty, W. R., Moultrie
McLeod, J. W., Moultrie
Paulk, J. R., Moultrie
Stegall, R. E., Moultrie
Stone, J. C. (Life), Doerun
Whittendale, W. H. (Life), Norman
Park
Withers, S. M. (Asso.), 76 Mathews
Drive, Columbus
Woodall, J. B., Moultrie

COWETA COUNTY

Arnold, J. H., Newnan
Barksdale, C. R., Jr., Grantville
Bryant, J. M., Jr., Newnan
Cochran, M. F., Newnan
Elliott, C. C., Sargent
Farmer, C. W., Jr., Newnan
Glover, H. C., Jr., Newnan
Glover, N. B., Newnan
Hammond, G. W., Newnan
Jackson, Bruce, Newnan
Kinnard, G. P., Newnan
McDonald, R. H., Newnan
Meaders, H. D., Newnan
Parks, J. W., Jr., Newnan
Peniston, J. B., Newnan
St. John, J. O., Newnan
Smith, W. P., Jr., Newnan
Tanner, W. H., Newnan
Tribble, J. M., Senoia

CRISP COUNTY

Dorminy, J. N. (Life), Cordele
Flourney, H. C., Warwick
Goss, C. C., Ashburn
Goss, Woodrow, Ashburn
Gower, O. T., Jr., Cordele
McArthur, C. E., Cordele
Whelchel, A. J., Cordele
Williams, H. J., Cordele
Williams, L. E., Cordele
Williams, P. L., Cordele
Williams, P. L., Jr., Cordele
Wootten, L. O., Cordele

DECATUR COUNTY

Baxley, H. B., Donalsonville
Bellville, C. G., Bainbridge
Bridges, E. C., Donalsonville
Bridges, H. A., Bainbridge
Chason, Gordon, Bainbridge
DuPree, T. E., Bainbridge
Ehrlich, M. A., Bainbridge
Fort, M. A., Bainbridge
Gibson, F. L., Bainbridge
Griffin, E. M., Bainbridge
Jenkins, H. B., Donalsonville
Mosley, E. E., Donalsonville
Tucker, J. P., Bainbridge
Wager, W. F., Bainbridge
Welch, C. B., Attapulgus
Wheat, R. F., Bainbridge
Wilkinson, W. L., Bainbridge
Willis, L. W., Bainbridge
Wright, J. T., Donalsonville

DEKALB COUNTY

Allen, H. H., 520 Church St., Decatur
Ansley, R. B., 121 Clairmont Avenue,
Decatur

Beck, J. E., 356 W. Ponce de Leon Avenue, Decatur
 Bloomer, W. E., 520 Church Street, Decatur
 Carter, H. G., Jr., 459 Candler Road, S. E., Decatur
 Codington, A. B., 524 Candler Road, Decatur
 Cooley, J. B., Lithonia
 Cunningham, C. E., 231 E. Ponce de Leon, Decatur
 Duncan, G. A., Masonic Temple, Decatur
 Evans, J. R., Stone Mountain
 Fort, C. A., Jr., Medical Arts Bldg., Atlanta
 Joel, Chas., Jr., 2117 N. Decatur Road, Atlanta
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 Lee, H. B., Masonic Temple Bldg., Decatur
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 McCurdy, W. T., Stone Mountain
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 Stewart, T. W., Lithonia
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 Vinson, T. O., DeKalb Co. Board of Health, Decatur

DOOLY COUNTY

Bishop, L. H., Unadilla
 Coleman, O. K., Vienna
 Daves, V. C., Vienna
 Davis, E. B., Byromville
 Kitchens, O. W., Byromville
 Malloy, M. L., Vienna
 Mobley, H. A. (Life), Vienna

DOUGHERTY COUNTY

Adams, G. B., Phoebe Putney Memorial Hospital, Albany
 Armstrong, E. S., 410 C. & S. Bank Bldg., Albany
 Berg, J. L., 305 N. Jefferson St., Albany
 Bowman, M. B., 403 Broad Avenue, Albany
 Cook, W. S., 238½ Pine St., Albany
 Dunn, R. G., Jr., 1150 Julia Street, Albany
 Field, W. M., Medical Bldg., Albany
 Hilsman, P. L., 200½ Broad Avenue, Albany

Holman, C. M., 220½ Broad Avenue, Albany
 Ingram, Lillian, 210 Callaway Bldg., Albany
 Irvin, I. W., C. & S. Bank Bldg., Albany
 James, A. E., 403 Broad Ave., Albany
 Keaton, J. C., C. & S. Bank Bldg., Albany
 Lamb, C. C., Phoebe Putney Memorial Hospital, Albany
 Lucas, I. M., 222½ Broad Ave., Albany
 Mann, D. S., Medical Bldg., Albany
 McCall, C. S., Jr., Liberty Theater Bldg., Albany
 McDaniel, J. Z., C. & S. Bank Bldg., Albany
 McKemie, H. M., 301 C. & S. Bank Bldg., Albany
 McKemie, W. F., Medical Building, Albany
 Neill, F. K., 100 N. Washington St., Albany
 Parrish, L. H., 604 N. Monroe Street, Albany
 Paschal, J. D., 717 N. Monroe St., Albany
 Redfearn, J. A., 222½ Broad Avenue, Albany
 Rhyne, W. P., 403 Broad Ave., Albany
 Roberson, P. E., Callaway Bldg., Albany
 Russell, P. T., 220½ Broad Avenue, Albany
 Seymour, G. E., 403 Broad Avenue, Albany
 Sutton, J. M., Jr., 412 Third Avenue, Albany
 Thomas, F. E., C. & S. Bank Bldg., Albany
 Thomas, N. R., C. & S. Bank Bldg., Albany
 Tye, J. P., 220 Broad Ave., Albany
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ELBERT COUNTY

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 Bailey, D. V., Elberton
 Johnson, A. S., Elberton
 Johnson, A. S., Jr., Elberton
 Johnson, J. E. (Life), Elberton
 Johnson, J. E., Jr., Elberton
 Johnson, W. A., Elberton
 Mattox, B. B. (Life), Elberton
 Mickel, C. A., Jr., Elberton
 O'Neil, J. B., III, Elberton
 O'Neil, Phylis J., Elberton
 Smith, A. C. (Life), Elberton
 Smith, F. A., Elberton
 Thompson, D. N., Elberton
 Ward, G. A., Route 1, Elberton

EMANUEL COUNTY

Brown, R. G., Swainsboro
 Powell, C. E., Swainsboro
 Smith, D. D., Swainsboro
 Youmans, S. S., Swainsboro

FLOYD COUNTY

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 Black, R. J., Rome
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 Bosworth, E. L., Rome

Brannon, Emmett, Rome
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 Crow, H. E., Battey State Hosp., Rome
 Culbreth, E. W., Lindale
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 Dawson, Harry, Shannon
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 Garner, J. S., Jr., Rome
 Garrard, J. L., Rome
 Gilbert, W. M., Harbin Clinic, Rome
 Hackett, W. G., Harbin Clinic, Rome
 Harbin, B. L., Harbin Clinic, Rome
 Harbin, R. M., Jr., Harbin Clinic, Rome
 Harbin, T. S., Harbin Clinic, Rome
 Harbin, W. P. Jr., Harbin Clinic, Rome
 Horton, H. C., Jr., 5 Cherokee Street, Rome
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 Ketchum, W. H., Battey State Hospital, Rome
 Lewis, W. H., Floyd Hospital, Rome
 May, W. D., Battey State Hosp., Rome
 McCall, J. T., Jr., McCall Hosp., Rome
 McCord, M. M., McCall Hosp., Rome
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 Moore, Cliff, Jr., 409 S. Broad Street, Rome
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 Norton, J. H., Jr., Cave Spring
 Norton, R. F., McCall Hospital, Rome
 Orton, Sarah P., Battey State Hospital, Rome
 Payne, R. F., Battey State Hosp., Rome
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 Smith, S. D., Rome
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 Wyatt, C. J., Jr., Harbin Clinic, Rome

FORSYTH COUNTY

Bramblett, R. H., Jr., Cumming
 Lipscomb, W. E., Cumming
 Mashburn, J. S., Cumming
 Mashburn, Marcus, Cumming
 Mashburn, Marcus, Jr., Cumming

FRANKLIN COUNTY

Brown, S. D., Jr., Royston
 Parker, G. M., Carnesville
 Poole, E. T., Lavonia
 Ridgway, R. E., Royston
 Smith, B. T., Carnesville
 Williams, J. W., Jr., Lavonia

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 Akin, John T. Jr., 384 Peachtree St., N.E., Atlanta
 Alden, Herbert S., 384 Peachtree St., N.E., Atlanta
 Allen, Eustace A., 384 Peachtree St., N.E., Atlanta
 Allgood, Pierce, 478 Peachtree St., N.E., Atlanta
 Allison, Gordon G., Grant Bldg., Atlanta
 Almand, Claude A., 105 Pryor St., Atlanta
 Amerson, J. R. (Asso.), 36 Butler St., Atlanta
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 Beasley, B. T., Hurt Bldg., Atlanta
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 Blalock, Tully T., 490 Peachtree St., N.E., Atlanta
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 Boger, Richard E., 490 Peachtree St., N.E., Atlanta
 Boland, Chas. G., 157 Forrest Ave., N.E., Atlanta
 Boland, Frank K., 478 Peachtree St., N.E., Atlanta
 Boland, F. Kells, Jr., 478 Peachtree St., N.E., Atlanta
 Boland, Joseph H., 478 Peachtree St., N.E., Atlanta
 Boling, Edgar, 490 Peachtree St., N.E., Atlanta
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 Brown, Joseph C., Conyers
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 Bryan, Wm. W., 710 Peachtree St., N.E., Atlanta
 Buckhaults, W. W. (Asso.), 36 Butler St., S.E., Atlanta
 Bunce, Allen H., 98 Currier St., N.E., Atlanta
 Burch, J. C., 224 Central Ave., S.W., Atlanta
 Burge, Dan, 21 Eighth St., N.E., Atlanta
 Burgess, Taylor S., 384 Peachtree St., N.E., Atlanta
 Burke, B. Russell, 490 Peachtree St., N.E., Atlanta
 Burnett, Stacy W., 56 Fifth St., N.E., Atlanta
 Burson, E. Napier, Jr., 1083 W. Peachtree St., N.E., Atlanta
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 Byrd, William M. (Asso.), 36 Butler St., S.E., Atlanta
 Byers, Kathleen (Asso.), 396 Wimbledon Rd., N.E., Atlanta
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- Cale, Ellsworth F., 24 14th St., N.E., Atlanta
- Calhoun, F. P., 478 Peachtree St., N.E., Atlanta
- Calhoun, F. P., Jr., 478 Peachtree St., N.E., Atlanta
- Camp, R. T., Fairburn
- Campbell, John D., 490 Peachtree St., N.E., Atlanta
- Campbell, Wm. E., Jr., 384 Peachtree St., N.E., Atlanta
- Candler, Robert W., 490 Peachtree St., N.E., Atlanta
- Carroll, Stevan M., Jr. (Asso.), 36 Butler St., S.E., Atlanta
- Carter, Albert W., Jr., Forest Park
- Carter, Sandy B., 28 Eighth St., N.E., Atlanta
- Cason, W. M., 286 Lindbergh Dr., N.E., Atlanta
- Cathcart, Don F., 490 Peachtree St., N.E., Atlanta
- Catron, I. T. (Life), 16 Avondale Plaza, Avondale Estates
- Chalmers, Rives C., 490 Peachtree St., N.E., Atlanta
- Chambers, Benjamin M., Grant Bldg., Atlanta
- Champion, W. L. (Life), 490 Peachtree St., N.E., Atlanta
- Chappell, Amey, 795 Peachtree St., N.E., Atlanta
- Childs, J. R., 384 Peachtree St., N.E., Atlanta
- Christian, Wm. H., Jr. (Asso.), 1690 Pineridge Drive, N.W., Atlanta
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- Claiborne, T. Sterling, 384 Peachtree St., N.E., Atlanta
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- Clarke, M. L. B., Candler Bldg., Atlanta
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- Clifton, Ben Hill, 478 Peachtree St., N.E., Atlanta
- Cobb, Claud P., Jr., 101 S. Church St., East Point
- Cofer, Olin S., 478 Peachtree St., N.E., Atlanta
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- Coleman, Reese C., Jr., 478 Peachtree St., N.E., Atlanta
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- Cross, John B., 384 Peachtree St., N.E., Atlanta
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- Dabney, W. C. (Life), Ocean Springs, Miss.
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- Davis, M. Bedford, Jr., 1083 W. Peachtree St., N.E., Atlanta
- Davis, Robert C., 98 Currier St., N.E., Atlanta
- Davis, Shelly C., 35 Linden Ave., N.E., Atlanta
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- Dimmock, Avary M., Hurt Bldg., Atlanta
- Dixon, P. K., Jr. (Asso.), Jonesboro
- Dobes, Wm. L., 478 Peachtree St., N.E., Atlanta
- Dobson, J. L., 27 Fourth St., N.E., Atlanta
- Dorough, W. S., 478 Peachtree St., N.E., Atlanta
- Dougherty, Mark S., 98 Currier St., N.E., Atlanta
- Dowling, George B. (Asso.), 230 Spring St., N.W., Atlanta
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- DuBose, L. M. (Asso.), 36 Butler St., Atlanta
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- Duncan, John B., 478 Peachtree St., N.E., Atlanta
- Dunlap, E. B., Jr., 384 Peachtree St., N.E., Atlanta
- Dunstan, Edgar M., 478 Peachtree St., N.E., Atlanta
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- Eberhart, Chas. A., 704 Piedmont Ave., N.E., Atlanta
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- Edgerton, M. T., Candler Bldg., Atlanta
- Edwards, Wm. T., Jr., 490 Peachtree St., N.E., Atlanta
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- Equen, Murdock, 144 Ponce de Leon Ave., N.E., Atlanta
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- Spier, Eugene, 1826 Meerdith Dr., N.W., Atlanta
- Spivey, Lee M. (Asso.), 36 Butler St., S.E., Atlanta
- Stambaugh, Norman F., Jr. (Asso.), 36 Butler St., S.E., Atlanta
- Staton, T. R., 710 Peachtree St., N.E., Atlanta
- Steadman, Henry E., 3021 Stewart Ave., Hapeville
- Stelling, Henry G., 3076½ Roswell Road, N.W., Atlanta
- Stephens, Amos L., Jr., 478 Peachtree St., N.E., Atlanta
- Stephenson, Robert H., 710 Peachtree St., N.E., Atlanta
- Stewart, Calvin B., 478 Peachtree St., N.E., Atlanta
- Stewart, C. C. (Asso.), 36 Butler St., S.E., Atlanta
- Stillerman, Hyman B., 26 Linden Ave., N.E., Atlanta
- Stoddard, S. D., Georgia Inst. of Technology, Atlanta
- Stokes, J. J., 384 Peachtree St., N.E., Atlanta
- Stone, Chas. F., 384 Peachtree St., N.E., Atlanta
- Stoner, Cyrus Hubert, Candler Bldg., Atlanta
- Strickler, C. W., 123 Forrest Ave., N.E., Atlanta
- Strickler, C. W., Jr., 123 Forrest Ave., N.E., Atlanta
- Sturdevant, Clinton E., Healey Bldg., Atlanta
- Sullivan, R. F. (Asso.), Piedmont Hospital, Atlanta
- Sutterfield, Gerald R., 3254 Peachtree Road, Atlanta
- Swanson, Cosby, 478 Peachtree St., N.E., Atlanta
- Swanson, Homer S., Emory University Hospital, Emory Hospital
- Tabb, Wm. G., Jr., 384 Peachtree St., N.E., Atlanta
- Tankesley, Robert M., 478 Peachtree St., N.E., Atlanta
- Tanner, Jas. C., Jr., 384 Peachtree St., N.E., Atlanta
- Taranto, Morris B., Mortgage Guarantee Bldg., Atlanta
- Tarplee, Scott L., 113 14th St., N.E., Atlanta
- Teate, H. L., Jr., 104 Ponce de Leon Ave., N.E., Atlanta
- Thebaut, B. R., Candler Bldg., Atlanta
- Thomason, C. Griggs, 106 N. East Point St., East Point
- Thomason, W. L., 729 Piedmont Ave., N.E., Atlanta
- Thompson, D. O., 478 Peachtree St., N.E., Atlanta
- Thompson, Frederick H., 35 Linden Ave., N.E., Atlanta
- Thompson, John W., 27 Eighth St., N.E., Atlanta
- Thompson, Ralph M. (Asso.), 360 Ponce de Leon Ave., N. E., Atlanta
- Thompson, Wm. R., 1083 West Peachtree St., N.E., Atlanta
- Thornton, Lawson, 478 Peachtree St., N.E., Atlanta
- Tidmore, T. L., 44 26th St., N.W., Atlanta
- Timberlake, G. B., Candler Bldg., Atlanta
- Timberlake, Lloyd F., 35 Fourth St., N.E., Atlanta
- Tottle, Geo. S. (Asso.), 36 Butler St., S.E., Atlanta
- Trimble, W. H., 478 Peachtree St., N.E., Atlanta
- Trusch, H. L. (Life), 1745 Harvard St., N.W., Washington, D.C.
- Tucker, Robert P., 115 Ware Ave., East Point
- Tuggle, Mildred V. (Asso.), St. Joseph's Infirmary, Atlanta
- Turk, L. N., Jr., Candler Bldg., Atlanta
- Turner, August B., 151 Ponce de Leon Ave., N.E., Atlanta
- Turner, John W., 151 Ponce de Leon Ave., N.E., Atlanta
- Turrentine, Paul E., 478 Peachtree St., N.E., Atlanta
- Upchurch, Wilborn E., Healey Bldg., Atlanta
- Upshaw, C. B., 18 Fourth St., N.W., Atlanta
- Usher, Glenn S. (Asso.), 50 Seventh St., N.E., Atlanta
- Van Buren, E., 768 Juniper St., N.E., Atlanta
- Van Dyke, A. H., Grant Bldg., Atlanta
- Van Fleit, Wm. E., Emory University Hospital, Emory University
- Vaughan, Edgar A., Jr. (Asso.), 36 Butler St., S.E., Atlanta
- Varner, John B., 478 Peachtree St., N.E., Atlanta
- Veatch, J. W., Jr., 490 Peachtree St., N.E., Atlanta
- Velkoff, Abraham S., 490 Peachtree St., N.E., Atlanta
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- Vincenzi, Rosina B. (Asso.), Piedmont Hospital, Atlanta
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- Vonderlehr, R. A. (Asso.), USPHS, Atlanta
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- Walker, Exum B., 490 Peachtree St., N.E., Atlanta
- Walker, John S., 104 Ponce de Leon Ave., N.E., Atlanta
- Walker, John F. (Asso.), Lawson VA Hosp., Chamblee
- Walker, John R., 992 West Peachtree St., N.W., Atlanta
- Wall, Hilton F., 21 Eighth St., N.E., Atlanta
- Wall, Margaret J., 151 Ponce de Leon Ave., N.E., Atlanta
- Ward, Emmett, 384 Peachtree St., N.E., Atlanta
- Ward, Wm. Cleveland, 36 Butler St., S.E., Atlanta
- Warkentin, John, 36 Butler St., S.E., Atlanta

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 Warnock, C. Murray, 478 Peachtree St., N.E., Atlanta
 Warren, Wm. C., Jr., 478 Peachtree St., N.E., Atlanta
 Waters, Wm. C., Jr., 663 West Peachtree St., N.E., Atlanta
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 Weinberg, Jas. I., 490 Peachtree St., N.E., Atlanta
 Weinberg, S. P., 704 Piedmont Ave., N.E., Atlanta
 Weinstein, A. A., 663 W. Peachtree St., N.E., Atlanta
 Weitz, Frank, 780 Juniper St., N.E., Atlanta
 West, C. M., Candler Bldg., Atlanta
 West, E. M., Candler Bldg., Atlanta
 Whipple, Robert L., Jr., 384 Peachtree St., N.E., Atlanta
 Whitaker, Wm. G., Jr., 490 Peachtree St., N.E., Atlanta
 White, Jas. R., 478 Peachtree St., N.E., Atlanta
 Whorton, Carl Merrill (Asso.), 36 Butler St., S.E., Atlanta
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 Wilkins, S. A., Jr., Winship Clinic, Emory University
 Williams, Geo. A., 710 Peachtree St., N.E., Atlanta
 Willingham, R. T. (Asso.), 36 Butler St., S.E., Atlanta
 Willingham, T. I., 56 Fifth St., N.E., Atlanta
 Wilmer, John G., 384 Peachtree St., N.E., Atlanta
 Wilson, Richard B., 490 Peachtree St., N.E., Atlanta
 Woodial, Joseph D., Forest Park
 Wolff, Bernard P., 384 Peachtree St., N.E., Atlanta
 Wood, R. Hugh, Emory University Hospital, Emory University
 Woody, Edgar, Jr., 384 Peachtree St., N.E., Atlanta
 Wooley, Lawrence F., 490 Peachtree St., N.E., Atlanta
 Worth, Jack J., Jr., 1434 Miller Ave., N.E., Atlanta
 Wright, Edward S., 384 Peachtree St., N.E., Atlanta
 Yampolsky, Joseph, 478 Peachtree St., N.E., Atlanta
 Yarn, Charles P., Jr., 384 Peachtree St., N.E., Atlanta
 York, Jesse H., 384 Peachtree St., N.E., Atlanta

GLYNN COUNTY

Avera, J. B., Brunswick
 Brawner, L. E., Box 94, St. Simons Island
 Burford, R. S., Brunswick
 Coe, H. M., Brunswick
 Collier, T. W., Brunswick
 Crichton, R. B., St. Simons Island
 Galin, A. N., 509 F St., Brunswick
 Greer, C. B., Brunswick
 Hicks, J. M., Andrews Bldg., Brunswick
 Johnston, T. H., 2117 Norwich Street, Brunswick

Kirchman, Herbert, 1616 Reynolds St., Brunswick
 McDaniel, S. P., Brunswick
 Mitchell, F. B., Jr., Brunswick
 Moore, H. L., Brunswick
 Muse, J. P., Brunswick
 Simmons, J. W., Brunswick
 Simmons, Mack, Box 257, St. Simons Island
 Towson, Ira G., Box 145, Sea Island
 Valenta, L. A., Darien
 Wilson, C. A., Jr., Brunswick
 Winchester, M. E., Brunswick

GORDON COUNTY

Acree, M. A., Route 2, Calhoun
 Banks, G. T., Fairmont
 Barnett, W. R. (Life), Calhoun
 Billings, J. E., Calhoun
 Hall, W. D., Calhoun
 Lang, L. R., Calhoun
 Purcell, Bill, Calhoun
 Steele, B. H., Fairmount
 Walter, R. D., Calhoun

GRADY COUNTY

Arline, T. J. (Life), Cairo
 DeLoach, A. W., Jr., Cairo
 Hancock, S. L., Cairo
 Rehberg, A. W., Cairo
 Reynolds, A. B., Cairo
 Rogers, J. V., Cairo
 Walker, W. A. (Life), Cairo
 Warnell, J. B. (Life), Cairo

GWINNETT COUNTY

Cain, Sylvester, Norcross
 Chastain, J. R., Buford
 Hinton, S. H., Lawrenceville
 Hutchins, Harry, Buford
 Hutchins, W. J., Buford
 Kelley, D. C., Lawrenceville
 Mason, M. H., Duluth
 Puett, W. W., Norcross
 Sims, F. A., Jr., Lawrenceville
 Smith, R. E., Buford

HABERSHAM COUNTY

Arrendale, J. J., Cornelia
 Barrett, Clara, State Board of Health, Atlanta
 Brabson, T. H., Cornelia
 Collins, Katherine R. (Life), Turnerville
 Garrison, D. H., Clarkesville
 Garrison, F. O., Demorest
 Hall, I. E., Jr., 13th and W Sts., Washington, D. C.
 Hardman, C. T., Tallulah Falls
 Henry, C. M., Clarkesville
 Hicks, L. G., Clarkesville
 Nicholson, G. T., Cornelia
 Roberts, B. J., Cornelia
 Tolhurst, G. M., Cleveland
 Walker, J. L., Clarkesville
 Walter, A. J., Sautee

HALL COUNTY

Banks, Rafe, Jr., 111 N. Main St., Gainesville
 Brady, L. P., Hiawassee
 Brown, P. F., Jr., Gainesville
 Burns, J. K., Jr., Gainesville
 Burns, J. K., III (Asso.), 40 Casquove Ave., Naval Base, S. C.
 Butler, C. G., P. O. Box 13, Gainesville
 Butler, E. E. (Sci.), Gainesville
 Chandler, B. B. (Life), Gainesville
 Davis, B. B., Gainesville

Garner, W. R., Gainesville
 Ghent, O. T., Gainesville
 Gilbert, B. P., Gainesville
 Grove, E. W., Downey Hospital, Gainesville
 Hardman, B. S., Gainesville
 Howard, M. L., Dahlonega
 Hulsey, J. M., Jr., New Holland Clinic, New Holland
 Joiner, Hartwell, Gainesville
 Lancaster, H. H., New Holland
 Maley, Virginia D. H., 321 S. Green Street, Gainesville
 McCarver, W. C., Jr., 115 Academy, Gainesville
 McCrum, B. A., 420 E. Broad Street, Gainesville
 Meeks, J. L., Gainesville
 Nalley, W. B., Helen
 Neal, L. G., Cleveland
 Neal, L. G., Jr. (Asso.), U. S. Navy, Cleveland
 Rogers, R. L., Gainesville
 Simons, D. C., Dahlonega
 Smith, M. H., Gainesville
 Titshaw, H. S., Gainesville
 Valentine, H. E., Jr., 319 N. Bradford St., Gainesville
 Ward, E. L., Gainesville
 Wheelchel, C. D., Gainesville
 Whitworth, C. W., 123 N. Main St., Gainesville

HANCOCK COUNTY

Earl, H. L., Clayton
 Jernigan, C. S., Sparta
 Tanner, D. E., Sparta

HART COUNTY

Cacchioli, L. G., Hartwell
 Harper, G. T., Dewy Rose
 Heaton, S. A., Jr., Hartwell
 McCurry, W. E. (Life), Hartwell
 Milford, J. H., Hartwell

JACKSON COUNTY

Allen, M. B., Hoschton
 Bowdoin, W. H., Statham
 Bryson, L. R., Jefferson
 Etheridge, E. H., Winder
 Harris, E. R., Winder
 McDonald, E. M., Winder
 Moore, L. W., Winder
 Pharr, L. P., Auburn
 Pittman, O. C., Commerce
 Randolph, W. Q., Winder
 Randolph, W. T., Winder
 Rogers, A. A., Commerce
 Rogers, A. A., Jr., Commerce
 Russell, A. B., Winder
 Scoggins, P. T., Commerce
 Stovall, J. T. (Life), Jefferson

JASPER COUNTY

Belcher, F. S. (Life), Monticello
 Greene, M. L., Monticello
 Lancaster, E. M., Shady Dale

JEFFERSON COUNTY

Bryant, V. L., Wadley
 Farris, J. J., Wadley
 Lewis, J. R., Louisville
 Pilcher, G. S., Louisville
 Pilcher, J. W., Louisville
 Pilcher, J. J., Wrens
 Revell, W. J., Louisville
 Williams, C. R., Wadley

JENKINS COUNTY

Mulkey, A. P., Millen
Mulkey, Q. A., Millen
Lee, H. G., Millen

LAMAR COUNTY

Corry, J. A., Barnesville
Crawford, J. B., Barnesville
Henry, G. T., Barnesville
Jackson, J. H., Barnesville
Pritchett, D. W., Barnesville
Taylor, S. B., Barnesville

LAURENS COUNTY

Anderson, R. T., Coleman Hospital,
Dublin
Avera, B. P., Jr. (Asso.), VA Hospital,
Dublin
Barton, J. J. (Life), Dublin (deceased)
Bell, J. A., Jr., Dublin
Bush, J. L., Douglas
Carter, J. G., Scott
Cheek, O. H., Dublin
Cheney, F. D. (Asso.), VA Hospital,
Dublin
Claxton, E. B., Dublin
Cobb, T. R., Jr., 107 Rowe Street,
Dublin (deceased)
Coleman, A. T., Dublin
Coleman, F. J., Dublin
Conner, D. H., 1631 Bellevue Ave.,
Dublin
Daniel, B. E., Dublin
Dodd, W. A., Wrightsville
Hicks, C. L., Dublin
Fernan-Nunez, M. (Asso.), VA Hosp.,
Dublin
Kennedy, Nell, Dublin
Lane, G. M., VA Hospital, Dublin
Moye, C. G., Rte. 6, Dublin
Quinn, D. E. (Asso.), VA Hospital,
Dublin
Stapleton, J. W., VA Hospital, Dublin
Ware, A. D., Toombsboro
Watkins, W. M., 107 Rowe St., Dublin
Brantley, J. G., Wrightsville

MACON COUNTY

Adams, J. F., Montezuma
Adams, T. M., Montezuma
Derrick, H. C., Oglethorpe

McDUFFIE COUNTY

Gibson, F. N., Thomson
LeRoy, A. G., Thomson
Maxwell, E. J., Jr., 719 Jackson St.,
Thomson
Riley, B. F., Jr., Thomson
Wilson, P. H., Thomson

MERIWETHER COUNTY

Allen, W. P., Woodbury
Bennett, R. L., Warm Springs
Bennett, V. H., Gay
Britt, L. P., Georgia Warm Springs
Foundation, Warm Springs
Chambless, Miriam W., Hamilton
Chambless, W. G., Hamilton
Ellis, W. P., Chipley
Gilbert, R. B., Greenville
Gucker, Thomas, III, Georgia Warm
Springs Foundation, Warm Springs
Irwin, C. E., Warm Springs
Jackson, H. C., Manchester
Jackson, T. W. (Life), Manchester
Johnson, J. A., Manchester
Johnson, J. A., Jr., Manchester
Johnson, L. C., Manchester

Kirkland, W. P., Manchester
Raper, H. S., Warm Springs Founda-
tion, Warm Springs
Smith, J. W., Jr., Manchester

MITCHELL COUNTY

Belcher, D. P., Pelham
Brim, J. C., Pelham
Crovatt, J. G., Camilla
Hackett, L. E., Camilla
Harwell, C. W., Camilla
Howard, C. L., Pelham
McNeill, A. A., Jr., Camilla
Pirkle, J. C., Pelham
Roles, C. L., Camilla
Stevenson, C. A. (Life), Camilla
Walker, E. M., Pelham
Williams, M. W., Camilla

MONROE COUNTY

Alexander, G. H., Forsyth
Bramblett, A. W., Jr., Forsyth
Goolsby, R. C., Sr. (Life), Forsyth
Hodges, T. L., Jr., Forsyth

MONTGOMERY COUNTY

Palmer, J. W., Ailey
Kusnitz, Morris, Jr., Alamo
Moses, W. M., Uvalda

MORGAN COUNTY

Dickens, C. H., Madison
McGeary, W. C., Madison
Nicholson, J. H., Madison
Porter, J. L. (Life), Rutledge
White, E. C., Madison

MUSCOGEE COUNTY

Beach, Bessie M., Martin Building,
Columbus
Berman, Dave, 1315 Fourth Avenue,
Columbus
Berry, A. N., Medical Arts Bldg.,
Columbus
Bickerstaff, H. J., Medical Arts Bldg.,
Columbus
Blanchard, Mercer, 204 11th Street,
Columbus
Blanchard, M. C., 204 11th Street,
Columbus
Boyer, H. H., Martin Bldg., Columbus
Brannen, O. C., Murram Building.,
Columbus
Brill, H. H., Jr., Martin Building,
Columbus
Brocato, Simone, 1509 Fourth Ave.,
Columbus
Bush, John, 1340 Fourth Avenue,
Columbus
Butler, C. C., Medical Arts Bldg.,
Columbus
Cain, E. J., Medical Arts Bldg.,
Columbus
Carter, C. B. (Life), 1545 Third Ave.,
Columbus
Chipman, R. A., Swift Bldg., Columbus
Clifford, W. S., Murrah Building,
Columbus
Comstock, G. W., U. S. Public Health
Service, Columbus
Conger, A. B., Jr., Martin Bldg.,
Columbus
Conn, L. R. M., 1229 Second Avenue,
Columbus
Conner, G. R., 1229 Second Avenue,
Columbus
Cook, W. C., Swift Bldg., Columbus
Cooke, W. L. (Life), Martin Bldg.,
Columbus

Cosby, F. L., Martin Bldg., Columbus
Curtiss, E. J. (Life), Martin Bldg.,
Columbus
Davidson, J. K., III, 300 Martin Bldg.,
Columbus
Dillard, G. J., Medical Arts Bldg.,
Columbus
Durden, J. G., Jr., 1344 Second Ave.,
Columbus
Dykes, A. N., 1229 Second Avenue,
Columbus
Edwards, F. D., 1344 Second Avenue,
Columbus
Elder, I. R., 1902 Eighth Avenue,
Columbus
Elkins, J. A., 1312 Third Avenue,
Columbus
Epps, G. L., City Hospital, Columbus
Fletcher, H. Q., Jr., 1327 Third Ave.,
Columbus
Fox, Brent, Medical Arts Building,
Columbus
Gibson, R. L., 1226 Third Avenue,
Columbus
Gilliam, O. D., Martin Bldg., Co-
lumbus
Graffagnino, P. C., Medical Arts Bldg.,
Columbus
Henderson, C. W., Swift Bldg., Co-
lumbus
Hobbs, A. C., Martin Bldg., Columbus
Horn, E. B., 1331 Third Avenue,
Columbus
Hughston, J. C., Medical Arts Bldg.,
Columbus
Hutto, G. M., Medical Arts Building,
Columbus
Jarrell, F. C., Jr., Martin Bldg.,
Columbus
Jenkins, W. F., 1444 Fourth Avenue,
Columbus
Jones, W. R., Martin Bldg., Columbus
Jordan, W. P., 1119 Fourth Avenue,
Columbus
Land, P. S., Martin Bldg., Columbus
Love, W. G., Jr., Medical Arts Bldg.,
Columbus
Mayher, J. W., 1344 Second Avenue,
Columbus
Mayher, W. E., 1344 Second Avenue,
Columbus
McWhorter, M. R., 1338 Fourth Ave.,
Columbus
Mitchell, L. C., 1327 Third Avenue,
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Moses, Alice, Box 146, Phenix City, Ala.
Munn, E. K., 1100 Third Avenue,
Columbus
Murray, G. S. (Life), 1427 Dingle-
wood, Columbus
Peacock, C. A., 1327 Third Avenue,
Columbus
Rhea, J. W., Swift Bldg., Columbus
Rivers, Phyllis J. A., 204 Eleventh St.,
Columbus
Rivers, W. P., Jr., 204 Eleventh St.,
Columbus
Roberts, L. J., Jr., Medical Arts Bldg.,
Columbus
Roddenberry, S. A., Martin Bldg.,
Columbus
Schley, F. B., 303 11th St., Columbus
Schuessler, G. D., 1437 Second Avenue,
Columbus
Skipper, W. G., 27-D Baker Village,
Columbus

Snelling, W. R., 1315 Fourth Avenue, Columbus
 Stapleton, J. L., 307 11th St., Columbus
 Storey, W. E., 1308 Third Avenue, Columbus
 Thompson, J. B., Medical Arts Bldg., Columbus
 Thrash, J. A., City Hospital, Columbus
 Threatte, Bruce, 204 11th St., Columbus
 Tillery, Bert, Medical Arts Building, Columbus
 Turner, H. H., Martin Bldg., Columbus
 Venable, D. R., 1523 Hilton Avenue, Columbus
 Walker, J. E., 1223 Third Avenue, Columbus
 Waller, R. M., Jr., 300-304 Murrah Bldg., Columbus
 Willis, J. N., Swift Bldg., Columbus
 Wolff, L. H., Medical Arts Building, Columbus
 Wooldridge, J. C. (Life), Murrah Bldg., Columbus
 Youmans, J. R., Doctors Building, Columbus

NEWTON COUNTY

Huson, W. J., Covington
 Mitchell, J. B., Jr., Porterdale
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 Palmer, C. B., Covington
 Paty, R. M., Jr., Covington
 Pierce, E. H. (Asso.), Mayo Clinic, Rochester, Minn.
 Sams, J. R., 305 Church St., Covington
 Swann, W. K., Covington
 Waite, S. L., 307 Floyd St., Covington

OCMULGEE COUNTY

Arnold, M. F., Broad St., Hawkinsville
 Baker, W. R., Hawkinsville
 Batts, A. S., Hawkinsville
 Bush, A. R., VA Hospital, Dublin
 Harp, S. L., 809 E. Tugalo St., Toccoa
 Smith, J. M. (Life), Cochran
 Smith, R. L., Cochran
 Whipple, R. L., Cochran

POLK COUNTY

Blanchard, W. H., Cedartown
 Chapman, W. A. (Life), Cedartown (deceased)
 Chaudron, P. O., Cedartown
 Elliott, C. B., Cedartown
 Good, J. W., Cedartown
 Griffith, J. E., Rockmart
 Hagan, J. H., Rockmart
 Lucas, W. H., Cedartown
 McGehee, J. M., Cedartown
 Ross, Grace R., Cedartown
 Spanjer, R. F., Cedartown
 Styles, O. R., Cedartown
 White, G. M., Rockmart

RABUN COUNTY

Boyd, G. H., Jr., Clayton
 Dover, J. C., Clayton
 Neville, Lester, Dillard

RANDOLPH COUNTY

Arnold, J. T., Parrott
 Daniel, E. F., Jr., Dawson
 Elliott, W. G., Cuthbert
 Harper, T. F., Coleman
 Kenyon, J. M. (Life), Richland
 Martin, F. M., Shellman
 Martin, R. B., III, Cuthbert
 Martin, W. D., Dawson

Mayo, E. A., Jr., Richland
 Patterson, J. C., Cuthbert
 Pugh, C. M., Lumpkin
 Quattlebaum, R. B., Fort Gaines
 Rogers, F. S., Coleman
 Sims, A. R., Richland
 Ward, J. A., Shellman

RICHMOND COUNTY

Agee, M. P., 753 Broad St., Augusta
 Alexander, R. P., 501 Sou. Finance Bldg., Augusta
 Allen, L. H., Medical College of Ga., Augusta
 Bailey, Ann A., 2320 Kings Way, Augusta
 Bailey, T. E., 315 Tenth St., Augusta
 Barfield, W. E., 802 Russell St., Augusta
 Battey, A. M., Jr., 1445 Harper Street, Augusta
 Battey, C. R., 921 Greene St., Augusta
 Battey, W. W., 1445 Harper St., Augusta
 Bazemore, J. M., 3023 Pine Needle Road, Augusta
 Beard, B. C., 739 Green St., Augusta
 Bedingfield, W. R., Sou. Finance Bldg., Augusta
 Bell, J. E., 1242½ Greene St., Augusta
 Bernard, G. T., 204 13th St., Augusta
 Bowles, L. L., Medical College of Ga., Augusta
 Boyd, W. S., 1020 Greene St., Augusta
 Brittingham, J. W., 1345 Greene St., Augusta
 Brown, S. W., Sou. Finance Bldg., Augusta
 Brown, T. P., Route 5, Thomasville
 Bryans, C. I. (Life), 967 Meigs St., Augusta
 Burdshaw, J. F. (Life), 2571 Mt. Auburn Ave., Augusta
 Burdshaw, W. J., 718 Monte Sano Avenue, Augusta
 Carswell, A. S., Sou. Finance Bldg., Augusta
 Carter, C. H., 1003 Bluebird Road, Augusta
 Chandler, J. L., Jr., Univ. Hospital, Augusta
 Chaney, R. H., 1445 Harper St., Augusta
 Clary, T. L., Jr., 842 Greene Street, Augusta
 Cleckley, H. M., University Hospital, Augusta
 Corbitt, M. O., 1309 Holden Street, Augusta
 Cranston, W. J., 1345 Greene Street, Augusta
 Davis, A. J., 3039 Pine Needle Road, Augusta
 Davis, D. A., School of Medicine, Univ. of North Carolina, Chapel Hill, N. C.
 DeVaughn, N. M., 124 Seventh Street, Augusta
 Duncan, J. A., Cordele
 Ellison, R. G., 1116 Kirk Pl., Augusta
 Everett, Theodore, 1345 Greene Street, Augusta
 Faulkner, Alva M. H., University Hospital, Augusta
 Flanagan, W. S., University Hospital, Augusta
 Fulghum, T. E., Sou. Finance Bldg., Augusta
 Fuller, W. A., 1345 Greene St., Augusta
 Goodwin, T. W., Sou. Finance Bldg., Augusta
 Gray, J. D., 842 Greent St., Augusta

Greenblatt, R. B., Univ. of Georgia School of Medicine, Augusta
 Hair, L. Q., 1138 Druid Park Avenue, Augusta
 Hamilton, W. F., Jr., University Hosp., Augusta
 Hargrove, R. B., Jr. (Asso.), University Hospital, Augusta
 Harper, H. T., Jr., 910 Marion Bldg., Augusta
 Harrell, H. P., Sou. Finance Bldg., Augusta
 Harrison, F. N., 407 Seventh Street, Augusta
 Haynes, G. O. (Asso.), VA Hospital, Augusta
 Henry, C. G., 842 Greene St., Augusta
 Hensley, E. A., 1812 Watkins Street, Augusta
 Hitchcock, J. P., 926 Telfair Street, Augusta
 Hock, C. W., Medical College of Ga., Augusta
 Holmes, L. P., Sou. Finance Bldg., Augusta
 Howard, T. J., 842 Greene St., Augusta
 Johnson, R. W., 1229 Greene Street, Augusta
 Jones, G. F., Jr., 1020 Greene Street, Augusta
 Kalish, J. T. (Asso.), VA Hospital, Augusta
 Kelly, G. M., 2233 McDowell St., Augusta
 Kelly, G. Lombard, Univ. of Georgia School of Medicine, Augusta
 Kennedy, F. A., Bath, S. C.
 Kilpatrick, A. J. (Life), Forest Hills, Augusta
 Kilpatrick, C. M., Sou. Finance Bldg., Augusta
 Klemann, G. L., Sou. Finance Bldg., Augusta
 Lacy, G. R., Jr. (Asso.), VA Hospital, Augusta
 Lee, F. L., 301 Tenth St., Augusta
 Leonard, R. E., 1109 Telfair Street, Augusta
 Levy, J. H., 1345 Greene St., Augusta
 Levy, Theodore, 943 Greene Street, Augusta
 Lewis, S. J., 1112-4 Sou. Finance Bldg., Augusta
 Luther, C. G., Jr., 926 Telfair Street, Augusta
 Major, R. C., University Hospital, Augusta
 Manganiello, L. O. J., University Hospital, Augusta
 Martin, J. M., 1445 Harper Street, Augusta
 Masengale, L. R., 1138 Druid Park Avenue, Augusta
 Matthews, W. E., Sou. Finance Bldg., Augusta
 McGahee, R. C., 1345 Greene Street, Augusta
 McGinty, H. C., 1001 Hickman Road, Augusta
 McInnes, G. F., University Hospital, Augusta
 McRae, D. R., Jr., 1345 Greene Street, Augusta
 Mealing, H. G., Sou. Finance Bldg., Augusta
 Michel, H. M. (Life), 1229 Glenn Ave., Augusta

Miller, Abraham, 1345 Greene Street, Augusta
 Miller, J. M., 1138 Druid Park Road, Augusta
 Milligan, K. W., 942 Greene Street, Augusta
 Mountain, G. W. (Life), 1121 Monte Sano Avenue, Augusta
 Mulherin, C. M., 1528 Gwinnett Street, Augusta
 Mulherin, F. X., 1345 Greene Street, Augusta
 Mulherin, J. L., 842 Greene St., Augusta
 Mulherin, P. A., 1427 Harper Street, Augusta
 New, J. S., 1445 Harper St., Augusta
 Norvell, J. T., 1240 Greene Street, Augusta
 O'Rear, H. B., University Hospital, Augusta
 Owings, R. S., University Hospital, Augusta
 Pennington, W. R., Lincolnton
 Perkins, H. R., 418 Sou. Finance Bldg., Augusta
 Persall, J. T., Jr., 302 Sou. Finance Bldg., Augusta
 Phillips, C. M., Jr., Medical College of Georgia, Augusta
 Phillips, H. S., 1082 Bertram Road, Augusta
 Philpot, W. K., 1345 Greene Street, Augusta
 Phinizy, Irvine, Sou. Finance Bldg., Augusta
 Pinson, H. D., 842 Greene St., Augusta
 Price, W. T., Leonard Bldg., Augusta
 Pryor, Carol G., 1333 Harper Street, Augusta
 Pund, E. R., Medical College of Ga., Augusta
 Rapp, E. W. (Asso.), VA Hospital, Augusta
 Reeves, Nathan, Univ. Hosp., Augusta
 Reeves, Ninette P., University Hospital, Augusta
 Rhodes, R. L., Sou. Finance Bldg., Augusta
 Rinker, J. R., Univ. Hosp., Augusta
 Roberts, W. H., 828 Greene Street, Augusta
 Rosborough, W. D. (Asso.), VA Hospital, Augusta
 Roule, J. V., Sou. Finance Building, Augusta
 Sanderson, E. S., Medical College of Georgia, Augusta
 Scharnitzky, E. O., 1262 Greene Street, Augusta
 Sell, M. B., Jr., 926 Telfair St., Augusta
 Sheppard, W. L., University Hospital, Augusta
 Sherman, J. H., University Hospital, Augusta
 Steed, W. A., 305 Tenth St., Augusta
 Sydenstricker, V. P., University Hospital, Augusta
 Templeton, C. M., Sou. Finance Bldg., Augusta
 Tessier, C. E., Masonic Bldg., Augusta
 Thigpen, C. H., Univ. Hosp., Augusta
 Thomas, D. R., Jr., Sou. Finance Bldg., Augusta
 Thoroughman, J. C., VA Hospital, Augusta
 Thurmond, A. G., 623 Greene Street, Augusta

Thurmond, J. W., 623 Greene Street, Augusta
 Timmons, C. C., 415 Milledge Road, Augusta
 Torpin, Richard, University of Georgia School of Medicine, Augusta
 Volpitto, P. P., Univ. Hospital, Augusta
 Voyles, W. R., Jr., 1020 Greene St., Augusta
 Wall, Bithel, University Hosp., Augusta
 Wammock, Hoke, University of Georgia School of Medicine, Augusta
 Wamock, Virginia S., 3012 Fox Spring Road, Augusta
 Waters, A. J., University Hosp., Augusta
 Watson, W. G., 623 Greene St., Augusta
 Weeks, J. L. (Life), Harlem
 Weeks, R. B., Sou. Finance Building, Augusta
 White, W. O., 1345 Greene St., Augusta
 Wilcox, E. A. (Life), P. O. Box 615, Beaufort, S. C.
 Wilkes, W. A., Univ. Hosp., Augusta
 Williams, D. C., Jr., 1345 Greene St., Augusta
 Williams, W. J., Sou. Finance Bldg., Augusta
 Willis, C. H., Jr., Washington Road, Augusta
 Wilson, J. P. (Asso.), University Hosp., Augusta
 Witham, A. C., University Hospital, Augusta
 Wright, G. W., 1345 Greene Street, Augusta
 Wright, P. B., University Hospital, Augusta
 Wylie, M. H., Sou. Finance Bldg., Augusta

SCREVEN COUNTY

Freeman, J. C., Sylvania
 Hawkins, Katrine R., Sylvania
 Hogsette, G. B., Sylvania
 Lanier, L. F., Sylvania
 Simmons, W. G., Sylvania

SOUTH GEORGIA

Austin, G. J., Jr., Valdosta
 Bennett, Sybil C., Valdosta
 Bennett, V. B., Valdosta
 Bird, Frank (Life), Lake Park
 Burns, D. L., Valdosta
 Campbell, J. L., Jr., 103 W. Brookwood Drive, Valdosta
 Clements, F. N., Adel
 Eldridge, F. G., Valdosta
 Gibson, I. M., Valdosta
 Giddens, C. C., Valdosta
 Giddens, I. S., Lakeland
 Giles, J. T., 205 E. Alden Avenue, Valdosta (deceased)
 Johnson, A. M., Exchange Bank Bldg., Valdosta
 Little, A. G., Jr., Valdosta
 McKey, E. S., Jr., 1306 N. Patterson Street, Valdosta
 Mixsen, E. H., Valdosta
 Mixson, J. F., Valdosta
 Mixson, J. F., Jr., Georgia Avenue, Valdosta
 Oliphant, J. B., Adel
 Owens, B. G., 1306 Patterson Street, Valdosta
 Parrott, J. T., Hahira
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 Peters, J. S., Jr., Nashville
 Robbins, A. I., Homerville

Saunders, A. F., Valdosta
 Schnauss, W. R., Adel
 Sherman, H. T., 1310½ N. Patterson Street, Valdosta
 Smith, E. J., Hahira
 Smith, J. R., Hahira
 Smith, J. G., Lowndes Co. Dept. of Health, Valdosta
 Smith, T. H., Valdosta
 Stump, R. L., Jr., Valdosta
 Thomas, F. H., Valdosta
 Thompson, E. F., Valdosta
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 Turner, W. W., Nashville
 Waugh, W. C., Nashville
 Williams, T. C., Rose Bldg., Orlando, Florida

SPALDING COUNTY

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 Black, G. E., Griffin
 Brandon, R. V., McDonough
 Brown, G. W., Griffin
 Clouse, J. E., Jr., Griffin
 Copeland, H. J., Griffin
 English, R. E. L. (Life), Griffin
 Floyd, T. J., Jr., Griffin
 Forrer, D. A. (Life), Griffin
 Foster, G. R., Jr., McDonough
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 King, H. C., Griffin
 King, W. R., Jr., Griffin
 Miles, W. C. (Life), Griffin
 Oshlag, A. M., Griffin
 Smaha, T. G., Griffin
 Stuckey, Ann, Griffin
 Walker, G. L., Griffin
 Watkins, J. W., Jr., Jackson
 Williams, V. B., 124 Poplar St., Griffin

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Ayers, C. L., Toccoa
 Chaffin, E. F., Toccoa
 Cleveland, P. B., Toccoa
 Edge, J. H. (Life), 356 Home Park Avenue, N.W., Atlanta
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 Heller, W. B. (Life), Lakemont
 McNeely, H. H., Toccoa
 Schaefer, W. B., Toccoa
 Shiflet, R. E., Toccoa
 Singer, A. G., Toccoa

SUMTER COUNTY

Boyette, L. S., Ellaville
 Cheves, L. C., Jr., Montezuma
 Collins, R. A., Jr., Montezuma
 Durham, B. M., Americus
 Fenn, H. R., Americus
 Gatewood, T. S., Americus
 Logan, J. C., Plains
 McMath, W. B., Americus
 Moorman, J. H., Jr., Peoples Hospital, Akron, Ohio
 Pendergrass, R. C., Americus
 Primrose, A. C., Americus
 Robinson, J. H., III, Americus
 Savage, C. P., Montezuma
 Seay, E. F., Marshallville
 Smith, Herschel A., Americus
 Thomas, Russell, Americus
 Wilson, F. A., III, Leslie
 Wise, B. T. (Life), Americus
 Wood, Kenneth, Leslie

TATTNALL COUNTY

Collins, J. C., Collins
Colson, A. C., Glennville
Hughes, J. M., Glennville
Jelks, L. R., Reidsville
Pinkston, A. G., Jr., Glennville
Strickland, L. V., Cobbtown

TAYLOR COUNTY

Beason, Lewis, Butler
Montgomery, R. C., Butler
Montgomery, R. C., II, Butler
Sams, F. H., Reynolds
Whatley, E. C., Reynolds

TELFAIR COUNTY

Born, W. H., McRae
Fussell, J. K., Route 1, Rhine
Jones, A. J. (Life), Jacksonville
Maloy, C. J., McRae
Mann, F. R., McRae
Mann, F. R., Jr., McRae
McMillan, T. J., Milan
McRae, D. B., McRae
Parkerson, S. T., McRae
Smith, F. A., Jr., McRae

THOMAS COUNTY

Baldwin, M. A., Thomasville
Bell, R. P., Thomasville
Bellhouse, Helen W., 12 Capitol Square,
S.W., Atlanta
Cheshire, H. L., Archbold Hospital,
Thomasville
Collins, J. J., Thomasville
Daniel, F. C., Pavo
Dillinger, G. R., Upchurch Building,
Thomasville
Friddell, W. F. (Life), Boston
Futch, T. A., Jr., Thomasville
Isler, J. N. (Life), Meigs
King, J. T., Thomasville
Little, F. A., Thomasville
McCollum, Wm., Thomasville
Mims, O. M., Thomasville
Mobley, J. W., Jr., Thomasville
Moore, H. M., Thomasville
Morton, J. B., Thomasville
Murphy, F. E., Jr., Thomasville
Neal, J. B., 809 Park Front, Thomasville
Palmer, J. I., Thomasville
Pepin, H. S., Jr., 210 S. Broad Street,
Thomasville
Readling, H. F., Thomasville
Reid, J. W., Thomasville
Sanchez, S. E., Jr., Barwick
Saye, E. B., Thomasville
Shepard, Kirk, 113½ S. Broad Street,
Thomasville
Stinson, F. F., Thomasville
Wahl, E. F., Thomasville
Wall, C. K., Thomasville
Wasden, H. A., Jr., Pavo
Watt, C. H., Thomasville
Watt, C. H., Jr., 900 Gordon Ave.,
Thomasville
Wine, Mervin B., Thomasville
Zinke, Erhardt, Meigs

TIFT COUNTY

Andrews, Ella F., Tifton
Edmondson, T. L., Tifton
Evans, E. L., 602 Love Ave., Tifton
Flowers, E. M., Tifton
Jones, R. E., Tifton
Lucas, P. W., Tifton
Pittman, C. S., Tifton
Pittman, C. S., Jr., Tifton

Winston, R. K., 526 Panmure Road,
Haverford, Pa.
Zimmerman, C. E., Tifton
Zimmerman, W. F., Tifton

TOOMBS COUNTY

Aiken, W. W., Lyons
Bedingfield, W. H., Vidalia
Darby, V. L., Vidalia
DeJarnette, R. H., Vidalia
Findley, C. W., Vidalia
Gross, O. S., Vidalia
McArthur, J. D., Lyons
Mercer, J. E., Vidalia
Youmans, H. D., Lyons

TRI-COUNTY (CALHOUN, EARLY, MILLER)

Baxley, W. C., Blakely
Beard, J. S., Edison
Crowdis, J. H., Jr., Blakely
Hattaway, J. C., Edison (deceased)
Holland, S. P., Blakely
Houston, W. H., Colquitt
Lamson, T. H., Arlington
Martin, J. B., Edison
Merritt, H. J., Colquitt
Merritt, J. W., Jr., Colquitt
Rentz, T. W., Colquitt
Sharp, C. K., Arlington
Shepard, W. O., Bluffton
Standifer, J. G., Blakely

TROUP COUNTY

Arnold, E. T., Jr., Hogansville
Avery, R. M., LaGrange
Bates, F. E., Pine Mt. Valley
Bozeman, J. D., Franklin
Callaway, Enoch, LaGrange
Caswell, D. F., Franklin
Chambers, J. W., LaGrange
Clark, W. H., LaGrange
Coward, C. T., LaGrange
Easley, C. S., Jr., LaGrange
Fackler, W. B., Jr., LaGrange
Fisher, G. B., Franklin
Freeman, T. N., Jr., LaGrange
Grace, K. D., LaGrange
Grady, H. W., City-County Hospital,
LaGrange
Hadaway, W. H., LaGrange
Hammett, H. H., LaGrange
Hammett, H. H., Jr., LaGrange
Hand, B. H., LaGrange
Harvey, C. W., Hogansville
Hendricks, W. M., LaGrange
Herault, P. C., Jr., LaGrange
Herman, E. C., LaGrange
Holder, J. S., LaGrange
Jones, H. T., West Point
Klenk, L. F., 700 Hill St., LaGrange
Lewis, J. W., LaGrange
McCall, W. R., LaGrange
McCulloh, Hugh, Jr., West Point
Mitchell, J. T., City-County Hospital,
LaGrange
Molyneaux, E. W., Hogansville
Morgan, J. C., West Point
Morgan, J. C., Jr., West Point
Norman, L. G., Jr., West Point
O'Neal, R. S., LaGrange
Park, E. R., LaGrange
Phillips, W. P., 107 N. Lewis Street,
LaGrange
Prescott, E. H., Troup Co. Dept. of
Health, LaGrange
Taylor, J. L., Franklin

Turner, J. R., LaGrange
Whitehead, C. M., LaGrange
Williams, C. O., West Point

UPSON COUNTY

Barron, H. A. (Life), Thomaston
Blackburn, J. D., 211 Thurston Avenue,
Thomaston
Bridges, B. L., 104½ East Main,
Thomaston
Carter, R. L., The Clinic, Thomaston
Dallas, R. E., Dallas-Gower Clinic,
Thomaston
Garner, J. E., 311 W. Main, Thomaston
Gower, W. J., 106 E. Main, Thomaston
Grubbs, J. H., Molena
Harris, C. A., The Rock
Head, D. L., Jr., 203 Hightower Street,
Thomaston
Jordan, T. C., Jr., P. O. Box 710,
Thomaston
Kellum, J. M., Thomaston
McKenzie, J. M., Thomaston
Mincey, R. J., Jr., The Clinic,
Thomaston
Sappington, T. A., The Clinic, Thom-
aston
Tyler, H. D., 308½ S. Center Street,
Thomaston
Woodall, F. M., Thomaston
Woodall, J. A., Thomaston
Woodall, W. P., Thomaston

WALKER, CATOOSA, DADE

Alexander, L. L., Rossville
Alsobrook, T. W., Rossville
Cochran, T. A., Ringgold
Cornett, D. M., LaFayette
Derrick, H. C., Jr., LaFayette
Gardner, J. L., Sulphur Springs
Harmer, A. A., III, Wildwood
Hoover, J. P., Rossville
Kitchens, S. B., LaFayette
Middleton, D. S. (Life), Rising Fawn
O'Connor, F. L., Rossville
Patterson, R. L., 207 Interstate Bldg.,
Chattanooga, Tenn.
Pattillo, G. M., care of Johnson Drug
Store, Alma
Pope, Roy, Jr., Chickamauga
Pruitt, M. C., 2209 Rossville Blvd.,
Chattanooga, Tenn.
Shepard, R. C., LaFayette
Shields, H. F., Chickamauga
Simonton, F. H., Chickamauga
Stephenson, C. W., Ringgold
Townsend, E. M. (Life), Box 66, Rte.
4, Ringgold
Vassey, G. C., Rossville
Wheeler, S. D., Wildwood

WALTON COUNTY

Anderson, M. W., Social Circle
DeFreese, S. J., Monroe
Floyd, C. S., Loganville
Head, Homer, Monroe
Huie, L. M., Monroe
Nunnally, H. B., Monroe
Stewart, P. R., Monroe
Thompson, Ernest, Monroe

WARE COUNTY

Adkins, H. T., Waycross
Bates, W. B., Jr., Waycross
Bradley, D. M., Waycross
Bussell, B. R., Waysross
Calhoun, W. C., Waycross
Collins, B. E., Waycross

Davis, Floyd, Ware County Hospital,
Waycross
DeLoach, A. W., Waycross
Ferrell, T. J., Waycross
Flanagan, W. M., Waycross
Fleming, A., Folkston
Goldman, Benj., Hazlehurst
Goldwasser, F. E., Alma
Hawkins, L. M., Blackshear
Hendry, G. T., Blackshear
Hendry, Katherine M., Blackshear
Hendry, W. A., Blackshear
Hooker, J. F., Waycross
Inman, W. O., Jr., Waycross
Jackson, J. M., Polkston
Knight, A. M., Jr., Waycross
Lee, W. E., Jr., Ware County Hospital,
Waycross
Massey, C. M., Waycross
Mauldin, J. W., Alma
McCollum, R. R., Jr., Kingsland
McCoy, W. R., Folkston
Minchew, B. H., Waycross
Mixon, W. D. (Life), Waycross
Muecke, H. W., Waycross
Oden, J. W. (Life), Blackshear
Oden, L. H., Jr. (Asso.), Tyndall Field,
Panama City, Fla.
Oden, T. E., Blackshear
Penland, J. E., Waycross
Pierce, L. W., 1003 Atlantic Avenue,
Waycross
Pomeroy, W. L., Waycross
Reavis, W. F., Waycross
Schneider, W. J., P. O. Box 365,
Folkston
Seaman, H. A., Waycross
Sharpe, W. W., III, Alma
Shuman, Vilda, Waycross
Smith, Leo, Waycross
Terry, D. B., Homerville
Trulock, A. S., Jr., VA Hospital,
Montgomery, Ala.
Victor, Samuel, Waycross
Yeomans, N. F., Waycross
Youmans, C. R., Hazlehurst

WASHINGTON COUNTY

Dillard, J. B. (Life), Davisboro
Helton, B. L., Sandersville
Helton, W. S., Sandersville

Hurt, M. W., Sandersville
King, W. R. (Asso.), Tennille
Lennard, O. D., Sandersville
Lever, J. E., Sandersville
McElreath, F. T., Jr., Tennille
Newsom, N. J., Sandersville
Newsome, E. G., Sandersville
Overby, N., Sandersville
Rawlings, Wm., Sandersville
Rogers, O. L. (Life), Sandersville
Taylor, Ralph L., Davisboro

WAYNE COUNTY

Harper, F. M., Jesup
Leaphart, E. C., Jesup
Leaphart, J. A., Jesup
Miller, R. E., Leaphart Hospital, Jesup
Perkins, W. H., Leaphart Hospital,
Jesup
Pumpelly, R. A., Jr., Jesup
Tyre, J. L., Screven (deceased)
Virusky, E. J., Leaphart Hospital, Jesup
Yeomans, J. W., Jesup
Yeomans, Una R., Jesup

WHITFIELD COUNTY

Boozar, A. M., Dalton
Bradford, J. E., Spring Place
Bradley, P. L., Dalton
Bradley, R. H., Chatsworth
Broadrick, G. L., Dalton
Carson, H. B., Chatsworth
Carson, W. P. (Asso.), 171 Evacuation
Hosp. (M. C. 01919061), APO 301,
c/o Postmaster, San Francisco, Calif.
Erwin, H. L. (Life), Dalton
King, H. U., Dalton
McGhee, E. T., Dalton
Mullins, J. N., Chatsworth
Ragland, F. B., Dalton
Rollins, J. C. (Life), 1211 W. Rugby,
College Park
Rosen, E. A., Dalton
Sams, H. L. (Life), Dalton
Starr, Trammell, Dalton
Whitfield, T. W., 505 W. Drawford,
Dalton
Whitley, J. R., Winder
Wood, D. Lloyd, Dalton
Yeargin, L. C., Dalton

WILCOX COUNTY

Bussell, J. A. (Life), Rochelle
Dorsey, H. A. (Life), Pitts
Estes, J. M., Abbeville
Harris, V. L. (Life), Rochelle
Owens, J. D., Rochelle

WILKES COUNTY

Adair, M. C., Washington
Cheves, H. L., Union Point
Duggan, A. D., Washington
Garner, J. W., Crawfordville
Harriss, H. T. (Life), Washington
Middlebrooks, T. W., Union Point
Nash, T. C., Philomath
Simpson, A. W. (Life), Washington
Simpson, A. W., Jr., Washington
Sims, L. S., Jr. (Asso.), USS Essex,
c/o Fleet P. O., San Francisco, Calif.
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Wills, C. E., Washington
Wills, C. E., Jr. (Asso.), 432-B Craig
Drive, Columbus
Wood, O. S., Washington

WORTH COUNTY

Bell, P. E. (Life), Sylvester
Crowe, N. J., Sylvester
Davis, H. G., Jr., Sylvester
Jefford, T. C. (Life), Sylvester
Stoner, W. P., Sylvester
Sumner, G. S., Sylvester
Tracy, J. L., Jr., Sylvester

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Davis, A. W., Warrenton
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Hendrick, A. G., Perry
Jolley, J. S., Homer
Killam, F. H., Greensboro
Marshall, A. S., Fort Valley
Middleton, O. D., Ludowici
Moon, J. B., Harlem
Saggus, J. G., Harlem (deceased)
Thornton, H. A., Jr., Greensboro

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December 31, 1952

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Broderick, Mrs. J. Reid, 37 East 49th Street, Savannah
Brown, Mrs. F. Bert, 17 East 52nd St., Savannah
Brown, Mrs. Walter E., 139 East Victory Drive, Savannah
Center, Mrs. A. H., 507 E. 48th St., Savannah
Cirincione, Mrs. Vincent J., Lamara Apartments, Savannah
Coward, Mrs. Allen W., 1221 East 49th Street, Savannah
Craig, Mrs. James B., 528 East 45th Street, Savannah
Crawford, Mrs. W. Barron, Jr., 2608 Atlantic Avenue, Savannah
Dancey, Mrs. William R., 308 East Gaston Street, Savannah
Daniel, Mrs. John W., Jr., 212 Garrard Avenue, Savannah
Demmond, Mrs. E. Carson, 1001 East Victory Drive, Savannah
Drane, Mrs. Robert, 204 E. Hall Street, Savannah
Duncan, Mrs. J. Harry, 11 East 51st Street, Savannah
Edwards, Mrs. Ernest G., Lamara Apartments, Savannah
Elliott, Mrs. John L., 210 East Huntington Street, Savannah
Faggart, Mrs. G. H., 18 W. Oglethorpe Avenue, Savannah
Fillingim, Mrs. David B., 718 East 52nd Street, Savannah
Fleming, Mrs. Paul Nelson, 11 West Park Avenue, Savannah
Freedman, Mrs. L. M., 140 East 44th Street, Savannah
Freeman, Mrs. T. R., Wymberly, Savannah
Fulmer, Mrs. William H., 38 East 52nd Street, Savannah
Gleaton, Mrs. E. Nesbert, 32 East 45th Street, Savannah

Goldenstar, Mrs. G. W., Wymberly, Savannah
Gottschalk, Mrs. R. B., 437 East 59th Street, Savannah
Graham, Mrs. Rufus E., 417 East 54th Street, Savannah
Ham, Mrs. Emerson, 1208 Brightwood Drive, Savannah
Henderson, Mrs. C. A., 1313 Brightwood Drive, Savannah
Holloman, Mrs. A. Leon, 821 East Victory Drive, Savannah
Holton, Mrs. C. F., 606 E. 45th Street, Savannah
Howard, Mrs. Lee, Jr., 626 East 52nd Street, Savannah
Howard, Mrs. Lee, Sr., Box 194, Rte. 3, Savannah
Kandel, Mrs. H. M., 432 Abercorn St., Savannah
Kanter, Mrs. Walter W., 502 E. 57th Street, Savannah
Kelley, Mrs. Albert J., 3402 Abercorn Street, Savannah
King, Mrs. Ruskin, 10 East Taylor St., Savannah
Lang, Mrs. G. H., 2801 Atlantic Ave., Savannah
Lange, Mrs. Stephen J., 11 Oleander Avenue, Savannah
Lattimore, Mrs. Rolston, 109 East 52nd Street, Savannah
Lawless, Mrs. Thomas F., 20 Chelsea Drive, Savannah
Lee, Mrs. Lawrence, Sr., Bluffton, S. C.
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Powers, Mrs. Leander K., 623 E. 54th Street, Savannah

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 Hammett, Mrs. H. H., Jr., 104 Ridgecrest Road, LaGrange
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The following is a list of medical officers who have been released from service recently or will be released at an early date. Please use this list, or put it into the hands of those who will, in trying to obtain physicians to practice in your community.

Dr. Sanford A. Mullen (Lt. MC, USNR) 1405 Peyton Pl., Macon, Ga. (Released 11-30-52).

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Dr. Sidney Z. Gellman (Lt., MC, USNR) 904 Ponce de Leon Ave., NE, Atlanta, Ga. (Released 11-1-52).

Dr. Hugh B. Haston, Jr. (Lt. j.g., MC, USNR) 910 N. Davis St., Albany, Ga. (Released 11-13-52).

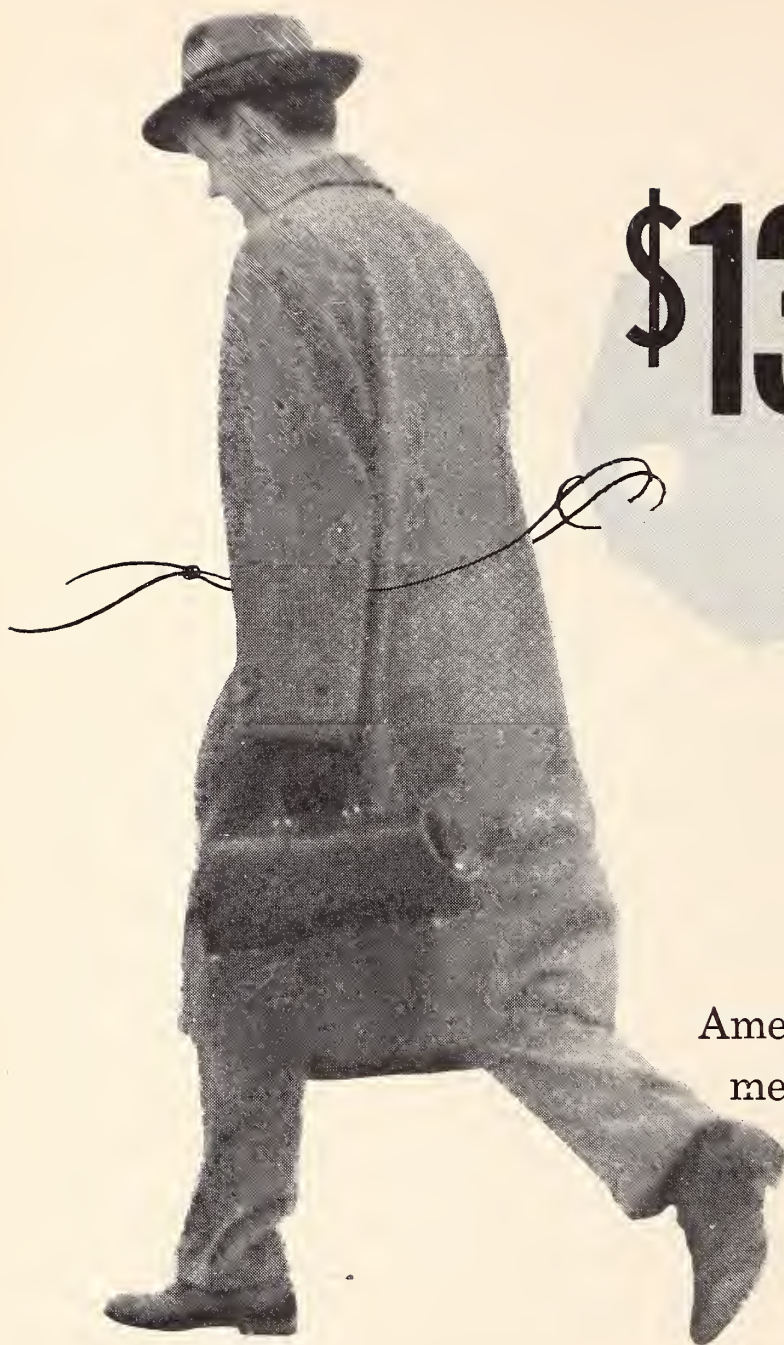
Dr. Jack A. Thompson (Lt., MC, USNR) 8 Mabry Road, Atlanta, Ga. (Released 10-16-52).

Dr. Talmage McK. Martin, Jr. (3380th Medical Group, Keesler AFB, Miss.) 333 Heard St., Elberton, Ga. (To be released 1-14-53).

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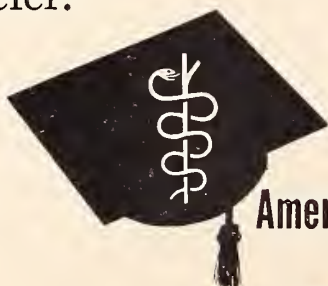
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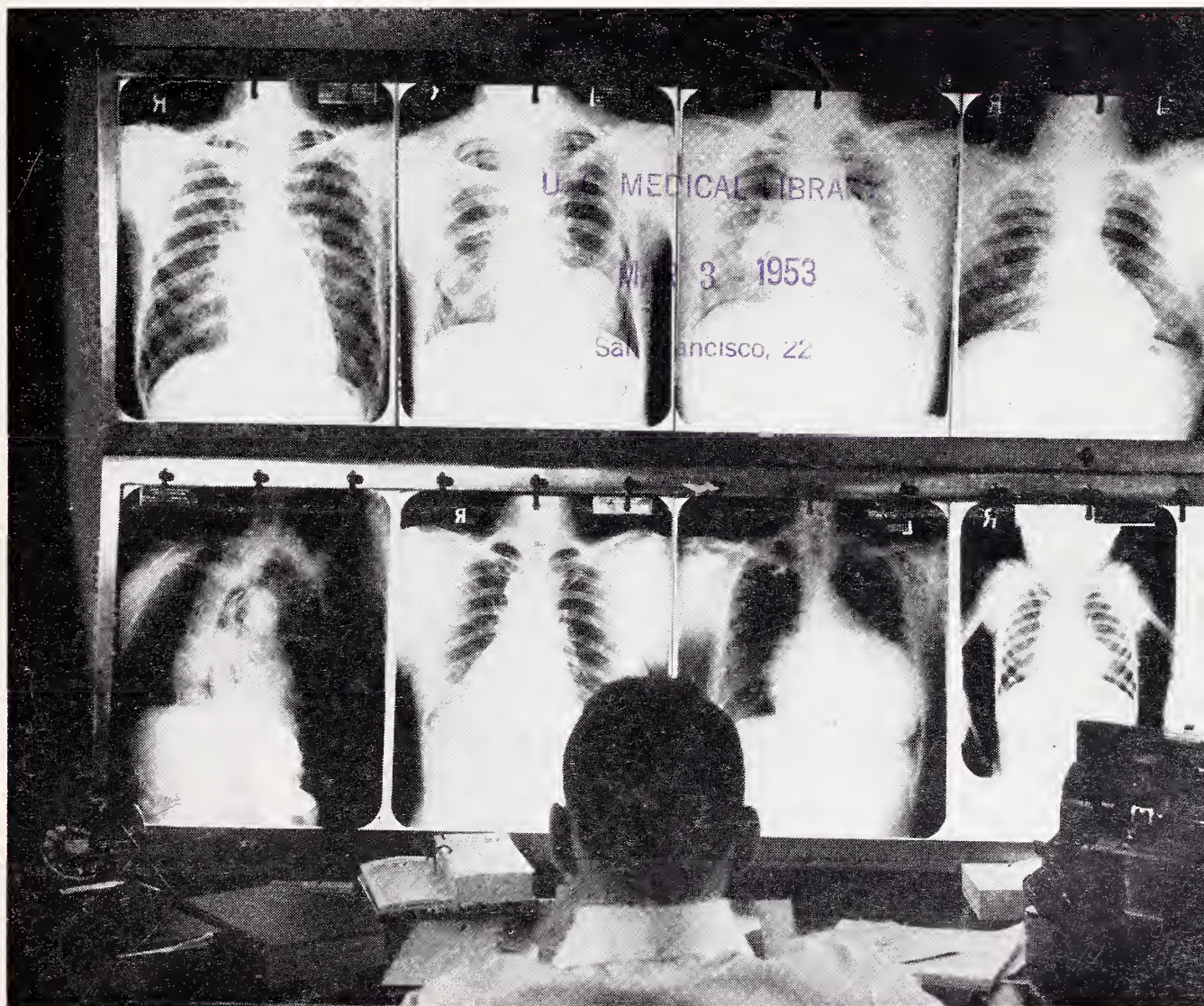


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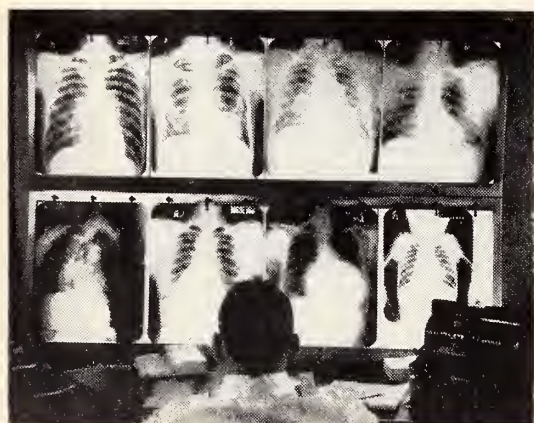


Photo by Ted F. Leigh, M.D.

If you have tried to diagnose the roentgenograms shown on the front cover, here is a checklist of the cardiovascular lesions reading from left to right, top row: (1) rheumatic heart disease with mitral stenosis; (2) aneurysm of the left ventricle; (3) atypical patent ductus arteriosus; (4) coarctation of the aorta. Bottom row: (1) calcified mitral ring; (2) situs inversus; (3) tuberculous pericardial effusion; (4) tetralogy of Fallot.

Our "Heart Issue" was compiled in cooperation with the Georgia Heart Association, which since its organization four years ago has worked closely with the MAG in the field of cardiology. This cooperation has resulted in expanded research, more intensified professional education and a system of 12 clinics for indigent heart patients.

Next month's issue of the *Journal* will highlight the annual March 30th observance of "Doctors Day."

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A. M. E. F. Page

The following physicians, listed by county medical society, have contributed to the AMERICAN MEDICAL EDUCATION FOUNDATION in January, 1953. Those making their contribution direct to the AMEF Headquarters may not be listed unless official notification has been received therefrom.

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Olliff, H. H.; Register

CARROLL COUNTY MEDICAL SOCIETY

Allen, C. H.; Bremen

King, O. D.; Bremen

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CHATHAM COUNTY MEDICAL SOCIETY

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CLARKE-MADISON-OCONEE COUNTY MEDICAL SOCIETY

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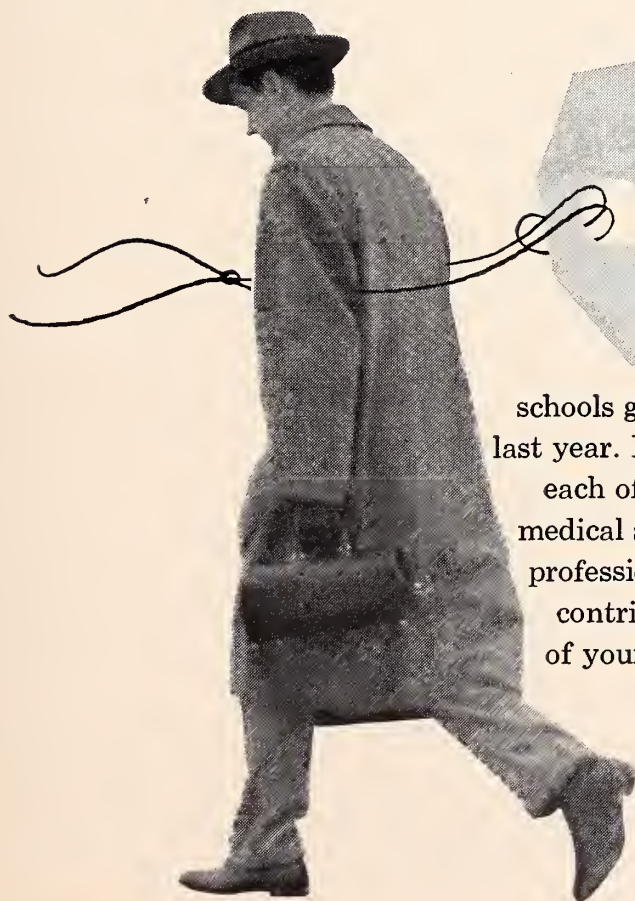
Minchew, B. H.; Waycross

Sharpe, W. W., III; Alma

Shuman, Vilda; Waycross

WILKES COUNTY MEDICAL SOCIETY

Adair, Morgan C.; Washington



\$13,356

America's medical schools graduated 6,135 new doctors of medicine last year. It costs more than \$13,356 to train each of them. Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.



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Education Foundation**

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The JOURNAL of the Medical Association of Georgia

Then deem it not an idle thing
A pleasant word to speak;
The face you wear—the thoughts you bring
The heart may heal or break.

Daniel Clement Colesworthy

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

GENERAL POLICY: The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Georgia.

MEDICAL EDITING SERVICE. If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

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1st District—Samuel A. Rosen, President, Savannah; Wm. H. Fulmer, Secretary, Savannah. Third Wednesday—March and July.
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Spalding—King, Harry, President, Griffin; Clouse, John E., Jr., Secretary, Griffin. First Tuesday in every month.
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5th District—Harry Lange, President, Atlanta; C. Purcell Roberts, Secretary, Atlanta. March and November.
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6th District—William Rawlings, President, Sandersville; C. H. Richardson, Jr., Secretary, Macon. Last Wednesday in June—First Wednesday in December.
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Hancock—Earl, H. L., President, Sparta; Tanner, David E., Secretary, Sparta.
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7th District—S. B. Kitchens, President, LaFayette; R. D. Walter, Secretary, Calhoun. First Wednesday in April; last Wednesday in September.
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Cobb—Garland, Charles M., President, Smyrna; Colquitt, Hugh S., Secretary, Smyrna. First Tuesday of each month (except June, July, August).
Floyd—Dawson, Harry, President, Rome; Wyatt, C. J., Jr., Secretary, Rome.
Gordon—Lang, Lewis, President, Calhoun; Purcell, Bill, Secretary, Calhoun.
Polk—Blanchard, Wm. H., President, Cedartown; Chaudron, P. O., Secretary, Cedartown.
Walker-Catoosa-Dade—Pope, Roy, Jr., President, Chickamauga; Cornett, Dennis, Secretary, LaFayette.
Whitfield—Bradley, Paul, President, Dalton; King, Hubert U., Secretary, Dalton. Third Wednesday of each month.

EIGHTH DISTRICT

8th District—L. W. Pierce, President, Waycross; Sage Harper, Secretary, Douglas. Second Tuesday—April and October.
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Coffee—Jardine, Dan A., President, Douglas; Harper, Sage, Secretary, Douglas.
Glynn—Towson, Ira G., President, Sea Island; Hicks, J. M., Secretary, Brunswick.
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Wayne—Virusky, E. J., President, Jesup; Perkins, Wm. H., Secretary, Jesup.

NINTH DISTRICT

9th District—Paul T. Scoggins, President, Commerce; Hartwell joiner, Secretary, Gainesville. April and September.
Blue Ridge—May, L. C., President, Blue Ridge; Hicks, Thomas J., Secretary, McCaysville.
Cherokee-Pickens—Andrews, Charles R., Jr., President, Canton; Hendrix, Arthur M., Secretary, Canton.
Forsyth—Bramblett, Rupert, President, Cumming; Mashburn James S., Secretary, Cumming.
Gwinnett—Hutchins, W. J., President, Buford; Hutchins, Harry, Secretary, Buford.
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Rabun—Neville, L., President, Dillard; Dover, J. C., Secretary, Clayton.
Stephens—Shiflet, Robert E., President, Toccoa; Ayers, C. L., Secretary, Toccoa.

TENTH DISTRICT

10th District—A. W. Simpson, President, Washington; J. B. Traylor, Secretary, Athens. Second Wednesday—February and August.
Clarke-Madison-Oconee—Hubert, M. A., President, Athens; Traylor, J. B., Secretary, Athens. Third Thursday—February and August.
Elbert—O'Neil, John B., III, President, Elberton; Mickel, Cary A., Jr., Secretary, Elberton.
Franklin—Brown, Stewart D., Jr., President, Royston; Roole, E. T., Secretary, Lavonia.
Hart—Harper, George T., President, Dewy Rose; Cacchioli, Louis G., Secretary, Hartwell.
McDuffie—Maxwell, Edgar J. Jr., President, Thomson; Riley, B. F., Secretary, Thomson.
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Walton—Head, Homer, President, Monroe; Nunnally, Harry B., Secretary, Monroe.
Wilkes—Stephens, R. G., President, Washington; Adair, M. C., Secretary, Washington.

REMEMBER THE DAY

THE 10-13 OF MAY

Medical Association of Georgia

103rd Annual Session at Savannah



In the Editor's Mail

Georgia Heart Association
June 1, 1952

To the Editor:

The Georgia Heart Association has voted to provide an annual lectureship on cardiovascular disease for the annual meeting of the Medical Association of Georgia, beginning with the meeting in 1953.

This lectureship will be in the amount of \$100.00, plus expenses of the speaker incident to his address.

We wish you every success for the Medical Association during the coming year.

Sincerely,

HARRY T. HARPER, JR., M.D.
President

Georgia Heart Association
August 1, 1952

To the Editor:

Dr. Thomas L. Ross, Jr. advises us that the Georgia Academy of General Practice has agreed to establish, in honor of the late *Dr. Walter W. Daniel*, an annual memorial lectureship on heart disease at its annual meeting, to the extent of \$100.00 if the Georgia Heart Association will furnish an equal amount.

I am pleased to advise that our board of directors has voted to provide \$100.00 annually for this purpose to match a similar amount from the Academy of General Practice.

Dr. Daniel was an active member of the Georgia Heart Association and has, in many ways, served the medical profession in Georgia.

Sincerely,

HARRY T. HARPER, JR., M.D.
President

Gilbert Franklin Douglas, M.D.
1923 Fourteenth Avenue South
Birmingham 5, Alabama

To the Editor:

It was so nice to open my mail this morning and find the December 1952, issue of the *Journal of The Medical Association of Georgia* on my desk. I have enjoyed going through this so much and I want to congratulate you on the fine manner in which

this has come through. You have a lovely format, the arranging is delightful and the *Journal* is really a credit to the State organization.

Trusting that you had a lovely Christmas Holidays and wishing for you and yours a most Happy 1953, I am

Most cordially yours,

GILBERT F. DOUGLAS, M.D.

Doctor Hal McCluney Davison
207 Doctors Building
Atlanta 3, Ga.

To the Editor:

I have just finished going through the December issue of the *Journal*. It is magnificent and you have done a marvelous job with it. My sincere congratulations and best wishes for your continued success in the work you have undertaken.

Fraternally yours,

HAL M. DAVISON, M.D.

Editor's Note: This kind of expression makes the systolic pressure go just a little higher—it also proves that reader interest is going higher.

United Red Feather Campaigns
December 31, 1952

To the Editor:

We're very grateful for your support and promotion of the United Red Feather Campaigns of America last fall.

As reports roll in from the Red Feather drives and united community campaigns all over our country, it looks as if the majority of them have met with success. Community and national health and welfare services will be able to carry through 1953 with effectiveness if the present trends hold. Conservative estimates indicate that more than \$250,000,000 will have been contributed by the generous American public.

Your help was a positive factor in the achievement of this fine result. You have the gratitude of millions of persons who benefit from the Red Feather services which these funds make possible.

Sincerely yours,

H. J. HEINZ II
National Chairman

MEDICAL ASSOCIATION
OF GEORGIA

Annual Meeting

DeSoto Hotel Hqs.

SAVANNAH

May 10-13, 1953

Features

Make Your Reservations

IMMEDIATELY

at

DeSoto Hotel

Savannah Hotel

Gen. Oglethorpe Hotel

in Savannah . . .

Scientific Exhibits

The space available for scientific exhibits is somewhat limited. If you would like to apply for space, please write to the office of The Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta. To be given consideration by the Committee on Scientific Work, these applications must be filed as soon as possible with this office.

SCIENTIFIC PAPERS . . .

. . . SCIENTIFIC EXHIBITS

REMEMBER THE DAY
THE 10-13TH OF MAY

MORNINGS

Sessions for general practitioners

AFTERNOONS

12 Specialty section meetings

GOLF TOURNAMENT

Tourney play on Sunday and Monday or Tuesday. Prizes!

GUEST SPEAKERS

12 outstanding medical authorities

DISTINGUISHED GUESTS

AMA President Louis H. Bauer

BUSINESS SESSION

House of Delegates meets Sunday P.M. and Tuesday P.M. Reference Committee meets Monday. Announcements of New Officers, etc. Wednesday noon.



The Bookshelf

BOOKS RECEIVED

The following books have been received and the courtesy of the publishers is gratefully acknowledged. Reviews of books that have particular interest to Georgia doctors will appear as space permits. Additional information in regard to all books received will be gladly furnished by this office.

OPERATING ROOM TECHNIC: By St. Mary's Hospital, Rochester, Minnesota. New, 4th Edition. 345 pages with 219 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price \$6.50.

THE LITERATURE ON STREPTOMYCIN: By Selman A. Waksman, 553 pages with 5,550 references. Rut-

gers University Press, New Brunswick, New Jersey, 1952. Price \$5.00.

NUTRITION AND DIET IN HEALTH AND DISEASE: By James S. McLester, M.D., and William J. Darby, M.D., Ph.D. Sixth Edition. 710 pages with 145 tables. Philadelphia and London: W. B. Saunders Company, 1952. Price \$10.00.

THE MEDICAL CLINICS OF NORTH AMERICA: Chicago Number, January Issue. Twenty-three contributors. 293 pages with 32 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price \$18.00 yearly subscription, \$3.00 per volume.

ELECTROCARDIOGRAPHY IN PRACTICES By Ashton Graybiel, M.D., and Paul D. White, M.D., Louise Wheeler, A.M., Conger Williams, M.D. Third Edition. 378 pages with 294 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price \$10.00.

REVIEWS

DISEASES OF METABOLISM edited by Garfield G. Duncan, Director of Medical Division, Pennsylvania Hospital, Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pa. 1,179 pages. W. B. Saunders Company, Philadelphia, Pa. 1952. Price \$15.00.

The third edition of Dr. Duncan's treatise on metabolic diseases follows the same general plan of the first and second editions. The objective is to supply information about the basic sciences to the general practitioner in a form that will relate this information to disease processes. The earlier chapters of the book concern themselves with general considerations of general metabolism, carbohydrate, protein, fat metabolism, water and mineral metabolism, and vitamin metabolism. In the latter chapters

disorders and diseases of metabolism are considered individually.

The current revision of this book comes at a time when tremendous advances are being made in the whole field of metabolic disease. The impact of the advent of adrenocorticotrophic hormone (ACTH) and Cortisone is apparent throughout the text. Isotope studies have also brought advancement in knowledge, particularly the use of radioactive iodine in diseases of the thyroid and in the study of thyroid metabolism. Modifications of protamine insulin, particularly NPH insulin, and the place of Vitamin B-12 in the therapy of anemias and neuropathies are also current additions to this field of information.

The practitioner of medicine, and particularly the internist, will find this treatise invaluable as an office reference book for specific metabolic problems that are encountered in practice. The physician who will find time to read and has interest in understanding disease processes will find here a review of basic principles of metabolism and an integration of current developments in knowledge with these principles.

W. DERREL HAZLEHURST, M.D.

SPECIAL MAG CONFERENCE — FEBRUARY 22

Presidents and Secretaries of All District and County Medical Societies

SUNDAY, FEBRUARY 22
9:30 a. m.

ACADEMY OF MEDICINE
875 West Peachtree St., N. E.
ATLANTA, GA.

PROGRAM

9:30 a. m.	Registration
10:00 - 11:45 a. m.	"WHAT IS THE MAG?", Mr. Sid Wrightsman, Jr., Atlanta, MAG Executive Secretary. "THE WOMAN'S AUXILIARY," Mrs. Ralph Fowler, Marietta, MAG Auxiliary President. "WHAT IS YOUR COUNTY SOCIETY H. Q.?", Mr. Thomas Hendricks, AMA Council on Medical Service, Chicago. "YOUR STAKE IN THE 83RD CONGRESS," C. H. Maxwell, M.D., Washington, Asst. Director AMA Washington Office.
11:45 a. m.	"Without Fear" (Film).
12:00 - 1:00 p. m.	DISTRICT CONFERENCE (County Society officers will meet with Councilors).
1:00 p. m.	LUNCH. Compliments of MAG. Wives invited
2:00 - 2:45 p. m.	PANEL DISCUSSION, William P. Harbin, Jr., M.D., Rome, Presiding <i>Theme:</i> "FUNCTION OF THE DISTRICT SOCIETY" <i>Moderator:</i> C. H. Richardson, Jr., M.D., Macon <i>Panel:</i> Frank A. Little, Thomasville; J. W. Chambers, LaGrange; William H. Fulmer, Savannah, and Hartwell Joiner, Gainesville.
2:45 - 3:30 p. m.	PANEL DISCUSSION, E. M. Lancaster, M.D., Shady Dale, Presiding <i>Theme:</i> "ORGANIZATION OF COUNTY SOCIETY" <i>Moderator:</i> Lawrence Lee, M.D., Savannah <i>Panel:</i> C. M. Henry, Clarkeville; W. J. Gower, Thomaston; W. K. Philpot, Augusta; Sage Harper, Douglas.
3:30 p. m.	DISCUSSION, DISTRICT ADVISORY SUBCOMMITTEES ON SELECTIVE SERVICE.



On The Bulletin Board

From:

HANS SELYE, M.D., Ph.D., D.Sc., F. R. S. (C),
Professor and Director of the Institute of Ex-
perimental Medicine and Surgery.

ALEXANDER HORAVA, M.D., Co-author of the "An-
nual Reports on Stress".

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In perusing the current literature with which this journal is concerned, we note that an ever increasing number of its articles deals with problems pertaining to research on "stress" and the so-called "adaptive hormones" (ACTH, STH, corticoids, adrenergic substances, etc.).

We are writing you because, in our opinion, the success of research in this complex and rapidly developing field largely depends upon the prompt availability and evaluation of relevant publications, a task for which we should like to solicit the assistance of your readers.

In 1950, our Institute has initiated the publication of a series of reference volumes entitled "Annual Reports on Stress" (Acta Medical Publishers, Montreal) in which the entire current world literature is sur-

veyed every year (usually between 2000 and 4000 publications). Up to now, we had to compile the pertinent literature partly from medical periodicals, monographs, abstract journals and partly from reprints sent to us by the authors themselves. Of all these, reprints proved to be the best source of data which we felt deserved prompt attention in our annual reports. Hence, in the past, we have sent out several thousand individual reprint requests to authors of whom we knew that they are currently engaged in research on stress and allied topics. Even this procedure did not give us the wide coverage which would be desirable, because it is materially impossible to contact all these authors individually and it often takes too much time to get the requested reprints.

It is evident that in order to insure prompt inclusion of publications in the annual reports, these surveys must develop into a cooperative effort between the authors of original papers and the reviewers. This cooperation was greatly enhanced of late by the publication of announcements, in several medical journals, encouraging investigators interested in stress research to send us their reprints for this purpose as soon as they become available.



About Our Contributors

CHARLES M. BALLENTINE, M.D., who is a Cardiac Fellow of the National Heart Institute presently at Emory University Hospital, wrote the article "The Low Salt Syndrome and Its Treatment." Dr. Ballentine graduated from the University of Michigan Medical School in 1948.

C. DANIEL BOWDOIN, M.D., of Atlanta is the author of the article "The Place of the Cardiac Clinic in Relation to the Public Health Program of Heart Disease Control." Dr. Bowdoin, a graduate of the Medical College of Georgia in 1933, is now the Special Consultant, USPHS, Division of Chronic Diseases.

ELLISON R. COOK, III, M.D., of Savannah, contributed the article "Prognostic and Therapeutic Implications of Classifications of Hypertensive Disease." Dr. Cook is a graduate of the Emory School of Medicine, 1943.

LOUIS K. LEVY, M.D., of Atlanta, wrote the article on "Intractable Heart Failure." Dr. Levy graduated from Tulane University of Louisiana School of Medicine in 1937.

ROBERT L. McMILLAN, M.D., of Winston-Salem, N. C., is a graduate of Duke University School of Medicine, 1933. Dr. McMillan is the author of the article "The Management of Auricular Fibrillation."

IRVINE H. PAGE, M.D., of Cleveland, Ohio, contributed the article "The Treatment of Severe Arterial Hypertension with Hexamethonium and Hydrazinophthalazine." Dr. Page is a graduate of Cornell University Medical College, 1926.

JEFF L. RICHARDSON, M.D., of Atlanta, is the author of the article "Does Exertion Precipitate Coronary Thrombosis?" Dr. Richardson graduated from Emory University School of Medicine, 1924.

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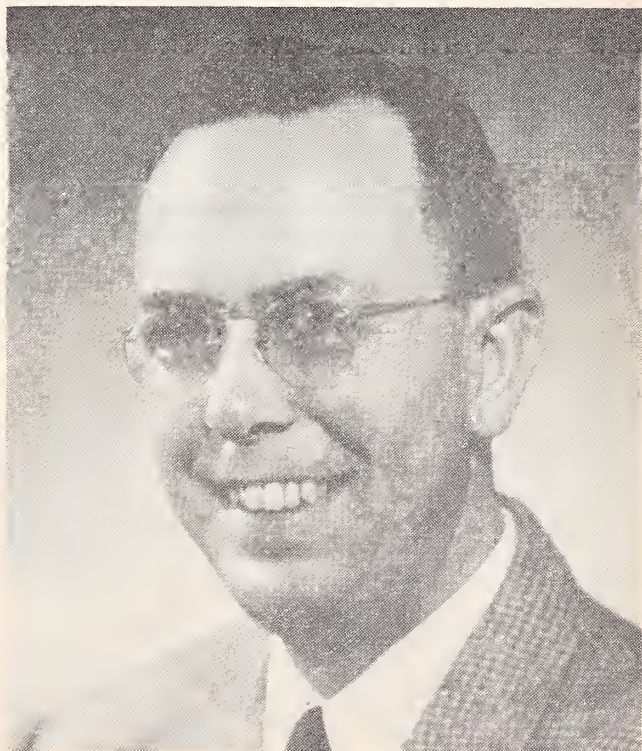
From the PRESIDENT *of the* GEORGIA HEART *Association*

As president of the Georgia Heart Association for the ensuing year, I welcome the opportunity to address those of you who are making our work possible by your continued participation and support.

The annual report of our activities which appears on other pages of this *Journal* attempts to select and report on the principal points of advance in our program during the past year. But these items, in their cold lines of type and necessary brevity, cannot portray for you the magnitude of the problem with which we are coping or the great sincerity of effort put forth by those of the Medical Association of Georgia who are active in the planning and carrying out of our Heart Association program.

The activities we mention and the advances we are able to cite are but the tangible manifestations of the philosophy and purpose which prompted the development of the Heart Association and which guides our efforts.

With more than 50 per cent of the annual deaths in our nation resulting from heart disease and more people chronically ill with heart disease than any other single cause, this is obviously a problem about which something must be done. Not only by the doctors but by the public. If we can prevent only a



Thomas L. Ross, Jr., M.D., President
Georgia Heart Association

few of these deaths or enable some of those with heart disease . . . whether the child with a rheumatic heart, the young man with hypertension, or the older man with a coronary . . . to lead fairly normal and productive lives, then our program is worthwhile. Of course, we not only can but are doing these things now. But our hopes and aims are set much higher . . . and we know much more can be accomplished.

That is why more and more funds are needed for scientific research as we delve deeper into the causes and possible prevention of the various forms of heart disease. That is why each new development in the diagnosis, treatment and management of heart disease must be brought immediately to the knowledge of every practicing physician. And that is why the Heart Association has the active participation of so many of the medical profession both in Georgia and

in the nation.

We are proud of the report we are able to make to you at this time. We are proud of our ever growing system of heart clinics for the medically indigent; of the advances made in meeting the challenge of rheumatic fever; of the constantly increasing knowledge and understanding of the heart and heart disease not only among the medical profession but by the public as well. But the entire problem is so great that there is little time to pause for satisfied contemplation.

In an era when "crusades" have become popular, we feel justified in considering ourselves embarked on a crusade. It is a crusade for healthier, more productive lives, and longer lives. We ask your continued interest and support.

THOMAS L. ROSS, JR., M.D.
President

Vocational Rehabilitation of

CARDIAC

The vocational rehabilitation of cardiacs is important from several standpoints. The number of persons involved is large—nearly eight million. If a large per cent of these persons are non-working dependents, they constitute a grave economic burden to society. If they are restored to work, they make an important addition to our labor pool and become a happier, self respecting, self supporting class. Experience in several large clinics and in private practice has shown that most cardiacs can and do work, and that, properly placed in selected jobs, they have less absenteeism, less labor turnover and less rejection of work than unhandicapped workers.

At the request of several large employers of labor the committee on vocational rehabilitation of the Georgia Heart Association has been attempting to help in the proper selection of cardiacs for work and proper job placement of such workers. Representatives of management, labor, law, industrial health, general practice, heart specialists, and insurance men have worked to understand and clarify the problems inherent in the employment of cardiacs. A most important objective of this committee is to acquaint the doctors in Georgia with these problems and to solicit their help and cooperation with the other parties involved in returning to work as many handicapped persons as possible.

A study of insurance and industrial compensation

problems affecting this group has been started and it is hoped that definite encouragement to employers to hire handicapped workers may result from their efforts.

In every possible way cooperation with the state division of vocational rehabilitation has been urged. This organization has agreed to furnish to the various heart clinics, sponsored by the Georgia Heart Association, job analysts and counsellors to help in the placement of cardiacs who can be returned to work, and training in suitable skills where indicated.

Through "Heart of the Home" programs help is brought to the housewives and homemakers or self employed women who do not have access to the larger industrial group care. This represents an important element of the work.

A special plea is made for doctors generally to cooperate in the study and discussion of the problems inherent in the employment of cardiacs. Especially needed is an agreement on what constitutes etiological relationship between job and disease in cases of coronary attacks occurring on the job. Large employers such as Eastman Kodak Company have returned to work more than 60 per cent of their workers who have had myocardial infarctions. We need to develop a more optimistic attitude toward the employment of such workers and to help in their rehabilitation after illness.

JOSEPH C. MASSEE, M.D.

Incidence and Reportability of

RHEUMATIC FEVER *in Georgia*

There has been a tendency to underestimate the prevalence and importance of rheumatic fever in the South although its incidence is only slightly less than in New England. There is too much of both the acute disease and its disabling late valvular heart damage. In a 1941 survey of all postmortem examinations at Grady Hospital over the five year period ending in 1940, 3.5 per cent of the cases showed rheumatic heart disease.

The accurate clinical diagnosis of this disease at times is difficult and it behooves us to keep in mind

its varying manifestations. And after arriving at a diagnosis of rheumatic fever we have another responsibility; that of reporting cases found to the State Health Department. Unfortunately the inadequate and incomplete reporting of this reportable disease has slowed down efforts to study statistically the incidence of the disease in Georgia. To this end the Georgia Heart Association urges all physicians to diagnose and report this serious disease and allow us to develop a more intelligent and competent statewide rheumatic fever program.

T. STERLING CLAIBORNE, JR., M.D.

SAMA Chapter at Medical College of Georgia

Since there has been some inquiry as to just what the Student American Medical Association is, it would perhaps be best in this first article to describe the organization and purpose of the association.

The SAMA began in Chicago, December 29, 1950. Here a constitution was adopted by the charter societies providing for the national organization. Any group comprising twenty-five per cent of the student body of an accredited medical school may petition the national House of Delegates for admission. If approved these societies may then draw up their own constitution providing for local organization.

Each chapter is represented in the national House of Delegates, being entitled to equal rights and one vote. From its ranks a president, vice-president, treasurer, and a seven man council are elected for a term of one year. An executive secretary and three senior councilors are appointed annually by the American Medical Association.

The purpose of the SAMA according to the constitution are "to advance the profession of medicine, to contribute to the welfare and education of medical students, to familiarize its members with the purposes and ideals of organized medicine, and to prepare its members to meet the social, moral, and ethical obligations of the profession of medicine."

The national growth has been so phenomenal that over 16,000 members are expected by the end of this year. The executive staff has enlarged to meet the additional demand, and the *SAMA Journal* is making a substantial profit. This excellent monthly publication has been a great success, including features by students and faculty members from every medical school in the nation.

The governing body of the local society is the Council, whose members are elected as representatives of the six fraternities. This is not undemo-

cratic since the fraternities comprise over ninety-nine per cent of the student body. From the Council the officers are elected by the Society members. The officers for the school year 1952-53 are: President Preston Ellington, Atlanta, Vice-president Frank Rizza, Savannah, Secretary-Treasurer Fred Lindsey, Tifton. Other members of the Council include: Janet Johnson, Dahlonga; Haskell Heller, Savannah; Charles Hatcher, Attapulcus; Fred Allman, Atlanta; James Dudley, Americus; Hubert Buxton, Sardis; Tommy Stapleton, Colquitt; and Bill Ariail, Cornelia.

The national constitution also requires an advisory committee selected by the society from the faculty, county and state medical associations. The faculty is represented by Doctors G. Lombard Kelly, Harry O'Rear, and Lester Bowles. The county and state organizations are represented by Doctors Harry Harper and David Henry Poer respectively.

We are indeed fortunate in having such splendid cooperation and interest shown by the faculty advisors and other medical societies.

Bill Ariail and Charles Hatcher were elected to the House of Delegates which met recently at the Sheridan Hotel in Chicago. Thirty-six of the forty-three societies were represented and sixteen new ones had their petitions approved. The scientific address was delivered by Dr. W. C. Alvarez stressing the importance of physical diagnosis. Among the subjects discussed were the doctors draft law, the Intern Matching and Student Health Plans.

We are especially proud of the SAMA chapter at the Medical College of Georgia. Our delegates have held positions of note in the national organization. We were a charter member and the first nationally to have 100 per cent student body membership.

JAMES C. DUDLEY

The Treatment of Severe

ARTERIAL HYPERTENSION

with HEXAMETHONIUM *and*

HYDRAZINOPHTHALAZINE

IRVINE H. PAGE, M.D., Cleveland, Ohio

Essential hypertension often requires little treatment because the vascular disease associated with it advances at so slow a pace. If, on the contrary, it accelerates, as in the severe or malignant phase, then drastic treatment is requisite. Toxemia of pregnancy may also be benefited.

Current treatment is based on the view that a decrease of arterial pressure to or towards normal levels is desirable and beneficial. There seems to be much truth in this hypothesis. It does not preclude the possibility that, in addition, treatment of the diseased blood vessels should not be thought of. But as matters now stand, with the possible exception of the use of pyrogens⁹, treatment of blood vessel disease is beyond the physician's capability.

We pointed out¹⁰ in 1937 that lowering of blood pressure as a result of sympathectomy caused definite improvement in both the electrocardiogram and size of the heart. This was later confirmed by many investigators. There is now little doubt that many of the signs of cardiac strain disappear when arterial pressure is reduced.

Thus it can be agreed that when the vascular disease, as exemplified in the eyegrounds, heart and kidneys, is advancing by increments measurable within periods of a year or two, lowering of the average arterial blood pressure is desirable. There are several ways of doing this, but we shall describe only the two latest in which we at the Cleveland Clinic are interested.

So far no one has found a single remedy which lowers blood pressure in all patients with essential or malignant hypertension. During the past 25 years we have repeatedly observed that about 20 to 30 per cent of patients respond by a lowering of arterial pressure to normal, to such measures as sympathectomy, drastic low-salt diet or even sedatives and psychological readjustment. But over all this time, an objective method has not been found for selecting patients who will respond to one or other treatment. If, for example, patients could be properly selected so that 95 per cent would exhibit an excellent result from sympathectomy instead of the usual 20 per cent, then there would be little question as to the place of sympathectomy in the treatment of the specific cases of hypertension. Despite the many suggested methods for selection such as the cold pressor test, the sodium Amytal test, the posture

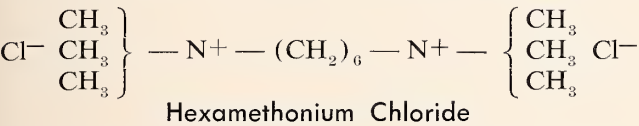
From the Research Division of the Cleveland Clinic Foundation, and the Frank E. Bunts Educational Institute, Cleveland, Ohio.

test, etc., none has proved satisfactory. Unfortunately, with the newer drugs which I will discuss there also is no method for selection. An adequate trial period is the only current way to determine whether the patient will or will not respond.

Hexamethonium

The attempt to lower blood pressure by removing vasomotor impulses is an old one and came to practical application in the surgical sympathectomies practiced since 1933.

The search for chemical methods of abolishing sympathetic vasoconstriction goes back many years. Without attempting to trace the origin of the problem, suffice it to say that Barlow and Ing¹ and Paton and Zaimis¹⁴ recognized in 1948 the importance of the methonium compounds in which two quaternary nitrogen groups are separated by a chain of CH₂ groups. The penta- and hexa-methonium compounds in which respectively 5 and 6 methyl groups occur, exert primarily a ganglionic blocking action.



Burn and Dale² in 1915 had shown the blocking action of the related tetraethyl ammonium compounds, thus providing the scientific background for clinical studies which eventuated in the hexamethonium compounds.

Several short term clinical studies were made of pentamethonium in England during 1949 which demonstrated the feasibility of using it to lower blood pressure and to cause peripheral vascular dilatation. Very wisely such communications as that of Turner²² pointed out the many important side effects of these compounds. Turner's observations have been repeatedly confirmed. There was little enthusiasm for its long term use as a treatment of hypertension. While there is no doubt that these studies demonstrate the acute hypotensive effects of the methonium compounds, the control studies on the patients are uniformly so poor it is impossible to guess the long-time effects of these drugs. Restall and Smirk¹⁵ and Grob and Harvey⁶ in 1950 initiated a more careful long term study to evaluate methoniums and in the past two years it has been under examination in a number of clinics in this country. Restall and Smirk have certainly had the widest experience in the use of these drugs, and were among the first to recommend them as a treatment for hypertension. Campbell and others^{3 4 8 22} in England have added important clinical observations, along with Finnerty and Fries⁵ in this country. Our own results of the past two years in considerable measure confirms theirs, and adds a somewhat more exhaustive analysis of the chronic effects of the drug in patients; chiefly, I believe, because of the exacting requirements for the control periods before treatment is started. A year ago, a summary of our findings¹¹ was presented in the *Journal of the American Medical Association*. Subsequently, several short-term studies by others

have appeared, some of which are enthusiastic and others far from it.

Hexamethonium is usually given by subcutaneous injection or by mouth. But since absorption from the gastrointestinal tract is irregular and incomplete, it is important to start the drug under close observation, preferably in the hospital. It is helpful to estimate the amount of drug required intravenously to lower blood pressure to normal with the patient propped up in bed. This estimate determines the initial subcutaneous dose. Another way is to determine the effect of a trial injection of 15 mgm. of hexamethonium. As Smirk¹⁹ found, the hypotensive effect is likely to be much greater in patients with especially high blood pressure than in those with moderate hypertension. We have found the same result in dogs with experimental neurogenic hypertension. Most of our patients have been started on subcutaneous doses of 0.1 to 0.5 mgm. per kilogram body weight twice a day and the dosage raised from 0.2 to 0.3 mgm. per week.

While it is true that most patients, regardless of the etiology of their hypertension, respond by a fall in blood pressure to a sufficiently large trial dose of hexamethonium, it does not necessarily follow that chronic treatment with the drug will lead to prolonged fall in supine blood pressure to or near normal.

The most impressive immediate effect of the drug is the development of orthostatic hypotension, which is most likely to affect the patient during quiet standing. This may become so incapacitating that the dosage need be reduced. To take advantage of the phenomenon of orthostasis, we have our patients sleep in a head-up bed and insist that they be up and about the room as much as possible. Elastic stockings aid in preventing too precipitous falls in blood pressure on standing. After weeks or months the patients tolerate the orthostatic hypotension; it becomes a less distressing syndrome and less severe. The arterial pressure taken in the supine position usually persists at elevated levels although when the patient stands, it may fall to zero.

Several weeks treatment are required to elicit a fall in the supine arterial pressure to or near normal. In some of our patients it has required months, not weeks! In others, no fall in average supine blood pressure has been obtained even after several months. Some patients from the beginning are highly sensitive to the drug, and over months may require surprisingly little to maintain normal blood pressure: the converse is true of more patients. Sensitivity is apt to increase during periods of severe diarrhea and electrolyte loss.

Repeated administration leads to development of tolerance. It is uncertain whether it may be lessened if the drug is given every 12 hours rather than every six. In any case, stopping treatment for several days quickly restores sensitivity and it may be resumed with benefit.

Our results seem to confirm Smirk²⁰ that the hypotensive action of the drug is enhanced, at least in

some patients, by the low salt diet (200 mg. of sodium in 24 hours). However, when there is little response to the drug, it is not apt to be made better by instituting the low-salt diet. Results comparing the drug before and after sympathectomy are less convincing. It has been somewhat irresponsibly claimed that lumbo-dorsal sympathectomy augments the response to hexamethonium, but proof of such a phenomenon has not yet been offered.

If the patient responds to the drug, fall in average supine blood pressure nearly to normal may be expected. Concurrently, changes in the eyegrounds of the malignant hypertensive clear in the course of weeks or months. Breathlessness, gallop rhythm, may entirely disappear. Renal blood flow may stay the same during the slow fall in average supine blood pressure, and proteinuria and hematuria almost disappear. At first the patient often feels much worse but then marked symptomatic improvement usually occurs. Headaches disappear quite promptly. The problem of severe, disabling hypotension continues to be vexing.

Hexamethonium has important side effects which have not been sufficiently recognized by physicians. Digestive disturbance is one of the first symptoms and it may progress from simple constipation to paralytic ileus. Loss of appetite may on occasion be serious. We have had some success using Urecholine (5 to 15 mgm.) or Myastinol to counteract these effects. Inability to read, due to the marked mydriatic effect of hexamethonium, tends to lessen as time passes: eserine drops sometimes help. Usually nothing need be done about it except to abstain from getting new glasses. Dryness of the mouth and pharynx may also cause considerable annoyance and this, like loss of accommodation, is due to parasympathetic paralysis.

Inability to empty the bladder may be very annoying. Hexamethonium treatment often seems to make manifest latent disturbances of bladder and prostate. Impotence and lack of ejaculation are not uncommon.

It is our impression, as it is that of Smirk, that the gastrointestinal disturbances may be more marked when the drug is taken by mouth. From 10 to 20 times as much is usually required when given this way than by the subcutaneous route. While there are many obvious advantages of the oral route, the irregularity of absorption and the gastrointestinal disturbances have caused its acceptance with misgivings.

Our experience has been that when using the drug by mouth it is very important to increase the dose very slowly. If the supine blood pressure has not fallen significantly after a total of 4 to 6 grams, it should be discontinued. Some patients show little fall in blood pressure while receiving the drug by mouth, but given subcutaneously a severe fall may be elicited.

Treatment of the severe hypertension of hypertensive encephalopathy by intravenous hexamethonium has proved quite successful in our hands.

Hexamethonium will never be an easy drug to use. Its many side effects and especially the postural hypotension when enough is given to lower the average supine pressure, make the drug impractical unless both patient and physician can work together closely on the many problems concerned with its action. There is certainly no need to use a drug with such dangerous potentialities in the slowly advancing essential hypertensive.

1—Hydrazino Phthalazine (Apresoline)

A second drug of very considerable interest is 1-hydrazino phthalazine. This is based in part on the work of Gross, Druey and Meier⁷ and Reubi¹⁶ in which it was shown that Apresoline was hypotensive and irregularly produced renal vasodilatation. The clinical tests with Apresoline were at first discouraging but further work by several groups of investigators showed the drug to be of far more value than the initial results indicated. Our own results have recently been summarized (Taylor, Dustan, Corcoran and Page²¹).

First it should be stated clearly that half or more of the patients do not respond to prolonged administration of Apresoline with a blood pressure fall to normal. Just as with other treatments for hypertension, there is no way to select those who will and those who will not respond. It appears to make no difference to what stage the disease has progressed as to its effectiveness as a treatment. Even those with malignant hypertension when they are "responders" exhibit complete reversal of the eyeground changes and betterment in the morbid vascular changes in the renal and cardiac beds. Some patients with chronic glomerulonephritis and pyelonephritis respond well.

Apresoline can be satisfactorily given by mouth. Its absorption, unlike hexamethonium, is smooth and it causes no especial gastrointestinal disturbance except loss of appetite. Arterial pressure may start to fall in a few days or not until after four to six weeks, when the progress down may be slow. At least two months trial of the drug up to full dosage of 800 mgms. per day should be given before it is discarded as a failure.

It is important for both physician and patient to know there are a number of side reactions which usually occur during the early trial period. Headache may be severe. Shortness of breath, palpitations and lightheadedness are common, especially when the patient is in the upright position. Loss of appetite and slight nausea are usual. Vomiting, diarrhea, malaise, muscle and joint pains, periorbital and pretibial edema, fever, fatigue, lessened libido in varying degree, make up the somewhat bizarre signs and symptoms during this early phase of treatment. Fortunately, in most patients they disappear spontaneously in a month or so.

The drug is administered in tablet form (25 mgm.) four times a day, after meals and at bed time. The dose can be raised in about a week to 100 mgm. q.i.d., and gradually then to levels of about 800

mgm. total daily dose, depending on the response of the arterial blood pressure. Some of the symptoms, if severe, may advantageously be treated with anti-histaminics, Cafergon, acetylsalicylic acid or sedatives.

The results of the use of this drug may be very satisfying if the patient is among those who respond. They are especially striking in those with malignant hypertension where the objective evidence of vascular disease is unmistakable. Our work demonstrates that the key to success in the use of this drug is persistence in its use until it is demonstrated beyond doubt that there is or is not a response. We have employed Apresoline in 107 carefully studied patients, some for two years; hence the belief that the views we are now developing are based on factual information rather than transient clinical impression.

Some clinicians combine Apresoline and hexamethonium along with the low salt diet. This is a reasonable regime if it is arrived at in a sensible fashion. So far it has not been demonstrated although it has been claimed by Schroeder^{17 18} that there is any synergism between hexamethonium and Apresoline. It must be assumed, until proved otherwise, that the hypotensive effects are additive. Each drug should be demonstrated to be effective separately and only then combined, if it appears desirable. The common mistake in such combined therapy is to continue to give a drug like Apresoline for months or years only to find that it has contributed nothing to the value of the hexamethonium treatment, but has effectively relieved the patient's pocketbook of obesity.

Surgical lumbo-dorsal sympathectomy has been claimed to sensitize to Apresoline. Our experience does not confirm this view. Clearly, no conclusion can be drawn on this complex issue until more and better evidence becomes available.

Summing up, it appears reasonable to believe that both hexamethonium and Apresoline mark advances in the treatment of arterial hypertension. They must

be given with great care and discrimination and, even so, many failures are to be expected. These drugs do not displace all the other measures of more established value in the management of hypertensives. They add something to the hope that more and more specific treatment will soon be found for a disease with many known and unknown causes, but they do not displace other more established forms of hypertensive patient management.^{12 13}

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Rheumatic and Congenital Heart Patient Referral

Detailed referral procedure for indigent cases of heart disease in children will shortly be distributed by the Georgia Heart Association. In the meantime, doctors may make use of the facilities provided through the cooperation of the Crippled Children's Division and the Heart Association by contacting either the local Public Health Office or the nearest Heart Clinic. Confirming diagnosis is available at

all heart clinics in the state; advanced diagnostic procedures at Atlanta and Augusta; and patients can be handled for hospitalization, surgery if indicated, and convalescent care. For further information contact your local health office, the Georgia Heart Association or the Crippled Children's Division.

AURICULAR FIBRILLATION

ROBERT L. McMILLAN, M.D., Winston-Salem, N. C.

It is now well established that auricular fibrillation is a serious disorder of the cardiac rhythm. When this arrhythmia develops in the heart the patient is laid liable to certain complications that will be either disabling or possibly lethal. The three most important of these are congestive heart failure, which may be ushered in by auricular fibrillation, peripheral or pulmonary embolus, or important psychiatric reactions which commonly develop as a result of the disturbing tumultuous palpitation.

Two types of auricular fibrillation should be recognized. The first is that associated with organic heart disease. Chronic rheumatic mitral valvular disease has long been known as the precursor of auricular fibrillation. Coronary arteriosclerotic heart disease with myocardial fibrosis—with or without hypertension—is another. The so-called thyrotoxic heart disease is frequently accompanied by auricular fibrillation, although it should be recognized that specific underlying cardiac lesions are present before the onset of thyrotoxicosis. Auricular fibrillation often occurs in hypertensive heart disease. It is unusual for this arrhythmia to occur in isolated aortic insufficiency due to syphilis of the aortic valve, but it does occasionally develop in patients with isolated rheumatic aortic involvement. This group encompasses those patients with the greatest incidence of auricular fibrillation, and it is noted that all save a small percentage in the thyrotoxic group have organic heart disease.

The second type of patient who has auricular fibrillation is rather unusual but not unimportant. This is the rare individual who, without any demonstrable

cardiac lesion, presents auricular fibrillation. The bulk of these patients give a history of paroxysms of tachycardia. Careful questioning reveals that the patient noted the heartbeat to be irregular. Often the fibrillation may be observed and recorded by the electrocardiograph. That this dysrhythmia should be considered lightly is untrue, since we have observed peripheral emboli and, with a long paroxysm the development of cardiac enlargement and failure in paroxysmal auricular fibrillation on several occasions.

Patients with auricular fibrillation, while divided into two classes, therefore become of unusual importance—although those with chronic auricular fibrillation present in greater degree the problems of embolism and cardiac failure than do those with paroxysmal auricular fibrillation.

Once confronted with the situation, it becomes important to decide whether to dispose of or just to contend with the auricular fibrillation. With this problem in view, we have undertaken to treat such patients with quinidine sulfate—determining blood levels, estimating such factors as the risk in the use of the drug, the amount necessary to revert auricular fibrillation to a regular rhythm, the maintenance dose, the toxic effects, the improvement of the patients from the standpoint of embolization, and the degree of cardiac failure.

This study was first reported by McMillan and Welfare¹ in 1947, and involved the treatment of 50 patients who mainly had severe, advanced cardiac failure—88 per cent of whom were reverted to normal rhythm without accident. A continuation of the work was reported in 1952,² in which 155 patients were reported. Those reverted to normal sinus rhythm on the regime to be described totalled 86 per cent. By now the total number reverted to normal rhythm has exceeded 300. There have been only three patients who have had emboli at the time of

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reversion to normal sinus rhythm. One was reverted twice, and 12 hours after reversion on these two occasions—he had a small pulmonary infarction in the right lung. Another patient had an embolus to the right lung base, and the third had a cerebral embolus which was fatal. The latter has been the only fatality attributable to the reversion to normal sinus rhythm in this series of over 300 reversions with quinidine sulfate. On the other hand, almost one-fourth of all patients with chronic auricular fibrillation have given histories suggestive of pulmonary or peripheral emboli prior to treatment with quinidine. The bulk of these emboli have been cerebral and many patients have had syncopal attacks, localized paralyses, motor aphasia and the like as the presenting pictures. In contrast to intracerebral hemorrhage or thrombosis, the recovery rate from cerebral embolus has, in our experience, been found to be good.

No embolus has occurred in our series after the rhythm has been restored to normal except for those reported above unless auricular fibrillation recurred in spite of maintenance doses of quinidine, in which case emboli have been common.

The patients treated have mainly fallen into class II to IV—according to the AMA functional classification and all have been unselected cases.

After treating a large number of patients, without reaction, the time-honored “initial test dose” was abandoned since no patient exhibited early reaction to the drug. All patients with congestive heart failure were digitalized prior to quinidine therapy. The program of treatment finally adapted after many trials is as follows: “Quinidine sulfate 0.2 Gm. every four hours day and night, omitting the 4 a.m. dose. At midnight with that dose of regular quinidine, give 0.4 Gm. of enteric coated quinidine sulfate.” The administration of enteric coated quinidine will prevent awakening the patient at 4 a.m., since absorption is delayed three to four hours. The dosage is increased by 0.1 Gm. each four hours each 24 hour period until normal rhythm is restored.

The bulk of patients with auricular fibrillation restored to normal rhythm will resume fibrillation without maintenance doses of quinidine. We have successfully adopted the policy of continuing the dose necessary for reversion for a day and then extending the time interval of the doses to hours which will better suit the living schedule of the individual. Quinidine, given on a four hour schedule, in most individuals, will produce a gradually accumulating blood level. It is therefore safe to lengthen the dosage interval to suit the patient. As an example, a patient who reverts to normal rhythm on 0.5 Gm. of the above regime, might well be given 0.5 Gm. at 7 a. m., noon, 5 p. m. and 10 p. m. along with 0.6 or 0.4 Gm. of enteric coated quinidine sulfate along with the 10 p. m. dose. Such a method of administration results in a reasonably consistent blood quinidine level twenty-four hours a day, which is necessary to prevent the recurrence

of auricular fibrillation. If the heart remains regular for two or three weeks on such a regimen, it is frequently possible to reduce the amount of quinidine in units of 0.1 Gm. per dose and yet sustain the normal cardiac mechanism.

In our studies² the average plasma concentration of quinidine was 10.6 milligrams per liter at the time of reversion. The average maintenance dose has been 5.3 milligrams per liter. Thus it is seen that the average maintenance dose is one-half that necessary for reversion. It is noteworthy that this is no hard and fast rule and that both the reversion doses and the maintenance doses must be made to fit the case.

The toxic effects of quinidine have, unfortunately, created its greatest interest and lack of use. The bulk of the symptoms are loss of appetite, nausea, diarrhea and vomiting. Some patients will complain of tinnitus headache, and a sensation of faintness. It is obvious that a sustained effort for reversion of fibrillation to a normal rhythm should be discontinued when toxic symptoms preclude further administration of the drug. Two patients developed temporary asystole with typical Stokes-Adams syndrome. Both had aortic regurgitation and both recovered. With increasing experience in the gradual administration of this drug the incidence of toxic reactions has decreased in contrast to the rapidly increasing doses.

Our observations have led us to believe that the older patients are reverted most readily since the average dose of quinidine is smaller and the blood levels are lower at the time of reversion.

Patients reverted from auricular fibrillation to a normal sinus rhythm have all exhibited a frankly increased cardiac capacity, embolization has been all but abolished, and all who were aware of their fibrillation have been relieved of palpitation and cardiac neurosis.

Not included in this series are patients with auricular fibrillation under unusual circumstances. The first of these are patients with auricular fibrillation during pregnancy. Three have been reverted with quinidine—two of which delivered normal offsprings with heart rates of 140 and 160 respectively. The third case had the drug discontinued twenty-four hours prior to delivery. Twelve cases of paroxysmal auricular fibrillation occurring during acute myocardial infarction were treated with quinidine sulfate alone with only one death. This patient had congestive heart failure before the infarction and was receiving digitalis prior to treatment with quinidine.

It is concluded from these studies that all patients with auricular fibrillation should be treated with quinidine sulfate slowly and, if the toxic symptoms are not too great, reverted to normal sinus rhythm and maintained in such a state.

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The

LOW SALT SYNDROME

and Its Treatment

The constancy of electrolyte concentrations and fluid volumes in the various compartments of the body within very narrow limits is necessary to maintain life. The various mechanisms for such exact control are little understood, but in general it can be said that sodium, the principle cation of the extracellular fluid, is regulated by the action of the adrenocortical hormones on the renal tubules, and water is controlled by the antidiuretic hormone of the posterior pituitary in the same manner. Such control is well maintained in health and even in many severe disease states through a variety of compensatory mechanisms. In a number of disease states, however, there comes a time when further compensatory changes in fluid or electrolyte composition threaten the life of the organism and at such times, control of the fluids of the body is relinquished to the primary disease process. For example, in the face of continual loss of electrolytes, or "salt" from the body, eventually the extracellular fluid will no longer keep concentrating to preserve a steady osmotic pressure in order that it may maintain an adequate circulating volume. This stage forecasts imminent disaster and its prompt recognition and treatment by the alert physician may often be life saving. Such recognition does not depend on the facilities of a research laboratory, but rather on the suspicions of a practitioner alerted to the possibilities of such a situation and observation of a few characteristic signs and symptoms.

The purpose of this paper is to briefly review a number of clinical conditions in which low concentrations of electrolytes are caused either by a primary disease process or its treatment, and to discuss the recognition and management of these common problems.

The Etiology of Low Sodium States

All the cells of the body have a certain osmotic

pressure which is determined by their constituents, and it is necessary that the extracellular fluid which bathes them have the same tonicity to prevent either dehydrating or overhydrating the cells. Normally this pressure is reflected in the circulating electrolyte concentration which averages 148-160 milliequivalents total base, of which 134 to 144 mEq represent sodium. This level is maintained by a number of mechanisms, an important one being the antidiuretic hormone which governs absorption of water or diuresis, depending on which way the osmotic pressure must be adjusted to equal the pressure inside the cells.

Release or inhibition of the secretion of ADH is governed by obscure means, but an important part of its control lies in the osmoreceptors located somewhere in the distribution of the internal carotid artery, and the exact level of ADH is therefore "set" by the normal osmolality of the body cells.

If one were to suddenly drink a large quantity of water, the dilution of serum electrolytes would result in a hypotonic solution which should then inhibit ADH secretion until the necessary diuresis returned concentration to normal. Conversely, if one rapidly injects hypertonic saline, ADH will greatly increase to insure enough water retention to balance the extra electrolyte.

A curious thing happens, however, upon the intravenous administration of isotonic saline. In the recumbent position this leads to decrease of ADH and diuresis. In the erect position ADH will vary but little and the fluid will be retained a long time. This has led to the concept of "volume receptors" in the same location as the osmoreceptors which respond to the circulating fluid volume in the non-expansile cranial cavity. An increase of volume occurring on recumbency will inhibit ADH and lead to diuresis, and this may also explain the "antidiuresis of quiet standing" so long observed. The cirrhotic with tremendous ascites and peripheral edema has most of his extracellular fluid below the diaphragm, and this

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may account for the increase of ADH, as well as the lack of destruction of excess hormones by a damaged liver. The paradoxical increase of ADH in spite of the hypotonic serum usually found in chronic congestive heart failure may likewise have a similar explanation, since here, too, the extra volume is usually pooled peripherally and does not reach the head.

Rarely, the body cells may have increased osmolarity, and this results in increased concentration of electrolytes with the ADH functioning as before, but "set" at a different level. Such a situation has been reported by Allott and Luetscher in certain types of cerebral disease, and Welt has described similar findings in patients after electroshock therapy. These cases have no signs or symptoms due to the electrolyte abnormality per se, and need no treatment.

In contrast, there are certain types of chronic wasting diseases in which one finds cellular hypoosmolarity with concomitant reduction of serum sodium and chloride. For example, in malnutrition and starvation, and in pulmonary tuberculosis, it is not uncommon to find a serum sodium of 120-125 mEq.

Cardiac Conference at Emory University Hospital

The patients with pulmonary tuberculosis and low serum electrolytes have been called, somewhat inappropriately, "pulmonary salt losers." Some patients with tuberculous meningitis will have the characteristically reduced spinal fluid chloride due merely to the reduced serum levels. Addison's disease is not a factor here as shown by a normal eosinophil response to ACTH and normal adrenal cortices at autopsy. If one attempts to alter the concentration of serum electrolytes in "pulmonary salt losers" by giving sodium chloride, it will either be excreted or result in edema. Desoxycorticosterone and ACTH merely expand the fluid volume and precipitate congestive heart failure, and giving water results in diuresis. The important point to recall is that ADH is "set" at a lower level here, and since the osmotic pressure of the cells matches that of the extracellular fluid, no signs or symptoms of disturbed tonicity are produced and no treatment is indicated.

Deficiency of serum electrolytes with normal cellular osmolarity, in contrast to the above hypoosmolarity, results in marked signs and symptoms and treatment is often urgently indicated. The Addisonian in crisis is a familiar example of this situation, although part of his clinical picture is due to the general effect of total adrenal cortical hormone

deficiency on the body's metabolism, and the elevated potassium is not as frequently found in other low sodium states.

"Salt losing nephritis", as pointed out by Thorn, may closely resemble Addison's disease, even to the pigmentation of the skin. This condition is commonly encountered in chronic renal insufficiency, and the hyponatremia is due to diseased tubules which no longer can perform the increased work of conserving base. Here adreno-cortical function is normal and the malfunctioning renal tubules will not respond to desoxycorticosterone, parathyroid hormone or pituitrin. The treatment is to replace electrolyte as it is lost.

In chronic congestive heart failure, although the total body sodium is increased, the serum sodium may be decreased. This must be sharply differentiated from the acute congestive failure seen, for example, following infarction of the left ventricle where the extra lung volume results from transferral of fluid from the periphery by a competent right ventricle, and where, obviously, there is no time for electrolyte disturbance to develop.

Excess sweating produces the well-known "Stoker's Cramps" and many men working in extreme temperatures at Boulder Dam died as a result of the continual loss of electrolyte, replaced only by drinking water. One of the forms of collapse due to prolonged exposure to the sun is due to this same mechanism. Replacement of electrolyte losses with enteric coated sodium chloride tablets is satisfactory prophylaxis.

Another interesting type of hyponatremia is the group of "cerebral" salt losers reported by Peters in which brain damage due to poliomyelitis, hypertensive cerebro-vascular accident and encephalitis caused a secondary renal tubular insufficiency resulting in the low salt syndrome. These patients responded well to treatment as compared to the "pulmonary" salt losers where no treatment is indicated.

Of all these low salt states, the most important are those acute episodes of salt depletion caused by over-zealous treatment. These conditions might properly be called "acute iatrogenic low salt syndromes." Internists, with vigorous use of mercurial diuretics at the same time sodium is being drastically reduced in the diet, succeed in washing sodium out of the body at a rate equaled only by the surgeons who fear "postoperative" sodium retention and replace losses with glucose solutions, while vomiting, suction, fistula losses, etc. continue to drain away seriously needed electrolytes.

Mercurial diuretics work primarily by paralyzing tubular resorptive mechanisms, allowing excess chloride to escape in the tubular fluid. The chloride combines first with sodium and secondly with potassium, the resulting salts carrying water of solution off, thus acting as a diuretic. Drastic limitation of sodium intake at the same time quickly results in a negative sodium balance unless the process is of brief duration. Repeated paracenteses in a previously fairly

well compensated cirrhotic will achieve the same effect. Ascitic fluid quickly reaccumulates and reaches equilibrium with the electrolytes of the body. Daily tapping soon results in sodium depletion, and the ensuing downhill course is often wrongly attributed to hepatic insufficiency. Similar results may occur in repeatedly removing the accumulated pleural transudates of congestive heart failure.

Gastrointestinal secretions have large amounts of basic ion and continual loss, whether by vomiting, obstruction, diarrhea, fistula drainage, or suction often leads to unrecognized electrolyte imbalance, especially if such losses are quantitatively replaced only by dextrose solutions. An exaggerated fear of "post-operative sodium retention" has often led to an even greater problem of salvaging a patient in the late stages of the low salt syndrome.

Excess subcutaneous dextrose solutions, if poorly absorbed, may form an unbelievably large pool of fluid, which, in reaching osmotic equilibrium, extracts large amounts of electrolytes from the serum, leaving the circulating fluid hypotonic. Occasionally the cation exchange resins, though usually producing a hyperchloremic acidosis, will produce the low salt picture.

These mechanisms of sodium depletion on one hand, and excess fluid administration on the other, soon exceed the normal protective compensatory ability of the body and the ensuing hypotonicity of the extracellular fluid results in two major changes in bodily physiology which explain the signs and symptoms observed. First, in an effort to reach osmotic equilibrium, fluid will leave the extracellular compartment and pass into the cells. This results in cellular overhydration of all the cells of the body—cerebral cortex, myocardium, and other vitally integrated organs. The shrinking circulating fluid volume ends in cardiovascular collapse and shock. Secondly, as serum chloride levels fall to approximately 80 to 85 milliequivalents, the kidney ceases to function. This is abetted by a falling blood pressure which shunts the dwindling blood supply away from the renal cortex and by the renal parenchyma already damaged by overhydration. In congestive failure, a certain amount of renal insufficiency exists even before such drastic changes are induced. The oliguria, and eventually, anuria, produced here is often wrongly interpreted as an indication for more mercurials, and a vicious circle is perpetuated. In any event, the resulting renal insufficiency leads to azotemia and acidosis, and terminally, to uremia, to further complicate the problem of cellular overhydration. Reversing the electrolyte pattern with good treatment at this point may nevertheless leave the residual of lower nephron nephrosis as an added hazard. Often serum potassium concentration falls or rises abnormally, depending on unpredictable tubular mechanisms and this, in itself, complicates clinical interpretation and management.

Signs and Symptoms

Overhydration of body cells with renal insufficiency and occasionally, potassium disturbances, results in a clinical syndrome easily recognizable, espe-

cially if one is alerted to this possibility when using methods of treatment known to precipitate a low salt state. Even the most expert clinician, with the best of laboratory facilities can inadvertently produce it, the important thing being its early clinical recognition and treatment.

Oliguria or rarely anuria are key signs to be aware of when occurring over several days time in a subject, especially an edematous one, receiving mercurial diuretics. Such a patient will show diminishing urinary chlorides during this time, until they disappear altogether. The edema present usually shows no change or may, in fact, increase, which is reflected in an increasing body weight. The cells of the skin may become so edematous and overhydrated that pressure with the thumb may leave the "fingerprint sign" persisting for several minutes. As renal insufficiency passes into renal failure the NPN and BUN rise and finally, serum electrolytes will show a drastic reduction of both chloride and sodium. We have frequently found such patients to have serum sodiums of 100-105 mEq. and chlorides of 60-70 mEq.

The symptoms the patient complains of may closely resemble those found in an Addisonian crisis. Usually there is marked drowsiness, weakness and lethargy, often wrongly attributed to sedatives or the disease process itself. Anorexia is marked, although thirst is variable. There may be nausea and vomiting. Abdominal and striated muscle cramps are common and, in addition, there will be superimposed all the signs and symptoms of increasing edema. Terminally, if the clinical course is not quickly arrested with adequate treatment, there is shock, stupor, convulsions from cerebral edema and death.

The diagnosis rests on eliciting early the signs and symptoms outlined above, especially no response to mercurial diuretics, and secondly, an accurate determination of serum electrolytes by the flame photometer method.

Differential Diagnosis

Mercurial diuretics, in addition to producing the low salt syndrome, more frequently cause hypochloremic alkalosis, superficially resembling the low salt picture, but less serious and requiring different treatment, and the two conditions should be sharply differentiated.

During the use of mercurial diuretics, as pointed out above, chloride is carried off in large amounts, and as the serum level falls, the CO_2 naturally increases to compensate, and hence the name "hypochloremic alkalosis." A reasonable approximation of the serum sodium concentration at any time here or in any condition without renal insufficiency can be obtained by adding the CO_2 in millimols per liter (NOT in vols.%) to the chloride in mEq. plus the additional factor of 12 to allow for other acid ions such as sulfates, phosphates, etc. It will then be found that the serum sodium is normal, and it may be inferred that tonicity is not altered, and that there is no interference with cellular hydration.

In contrast, the low salt state may have the same chloride level, but CO_2 is generally NOT increased

and the serum sodium is lowered, resulting in hypotonic extracellular fluid. These data are summarized in Figure 1 in a greatly oversimplified form disregarding all serum electrolytes except sodium, chloride and CO₂. This diagrammatic figure is modified from Gamble.

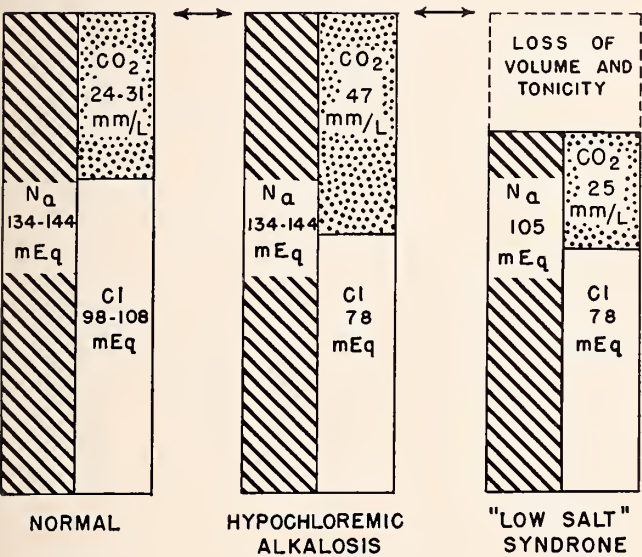


Figure 1.

Prophylaxis and Treatment

As usually the case, the best treatment for these two conditions is adequate prophylaxis to prevent their occurrence. When vigorously using mercurial diuretics or otherwise depleting the body of electrolytes, it is unwise to drastically reduce the sodium content of the diet simultaneously. Actually, mercurials work better with a normal intake of sodium and chloride and, in the long run, more fluid will be lost by keeping electrolytes at a normal level, yet we often see patients admitted in congestive failure and placed on a "low salt" diet at the same time daily mercurials are ordered. We feel a three pound weight loss in these patients per day is adequate, and that one should not try to have them lose all edema overnight.

Ammonium chloride is especially useful in these patients, its chief limitation being gastrointestinal intolerance. In general it has two uses. First, to be used as a diuretic in itself it is well to remember that anything less than 5 gms. of NH₄Cl a day is not a diuretic, and we generally prescribe .5 gm. enteric coated tablets, to take three or four tablets four times a day—before each meal and at bedtime for three days out of the week. After three days the renal tubules have so elevated their own NH₃ synthesis to cope with the extra chloride secreted, that sodium is no longer carried off and there is no longer any marked diuresis or sodium depletion. A rest of three to four days returns tubular function to normal, and the intermittent use of NH₄Cl in this manner achieves the best results.

A second use is to try to maintain serum chloride at a normal level to prevent hypochloremic alkalosis, and here one simply administers one gm. of NH₄Cl before meals and at bedtime continuously while mercurials are used.

If rather severe hypochloremic alkalosis develops one can correct it by giving NH₄Cl tablets in the enteric form, or, if necessary, 2 per cent NH₄Cl can be given intravenously. Such drastic treatment is seldom necessary, however, and with good renal function, a perfectly adequate form of treatment is intravenous normal saline. One should remember that a liter of normal saline has about 8.6 gms. of NaCl or about 148 mEq of both Na and Cl⁻ and that, while this is close to the normal serum sodium concentration of 134-144 mEq, it has a great excess of chloride over the normal serum levels of 98-108 mEq. This is the basis for saying normal saline is actually an "acid" solution. The main point here is that there is no deficiency of sodium and we have only to correct the deficiency of chloride.

In the low salt syndrome there is quite a different situation. Here there is little, if any, deficiency of total body fluid and the body cells are already overhydrated. There is, however, a great deficiency of both sodium and chloride, and our problem becomes one of replacing electrolyte with minimal quantities of fluid. The carbon dioxide combining power here may be normal or low as fixed acid metabolites accumulate, but has not been found to be elevated as in hypochloremic alkalosis.

Theoretical considerations can be most simply handled by referring to an actual case. A middle aged woman with well compensated heart disease and aortic insufficiency was seen several days following a hysterectomy for malignancy because of a continual post-operative downhill course, confusion, lethargy, drowsiness and weakness. Her serum sodium was found to be 101 mEq and her chloride 67 mEq. Normally, a 60 kg. adult can be assumed to have an extracellular volume of about 12 liters, and with the first signs of peripheral edema, this volume has expanded to at least 20 liters, which makes a convenient, though crude quantity for calculating these deficits. If we assume this patient's normal serum sodium was 141 mEq, it is quickly seen that each liter of her extracellular fluid has a deficiency of 40 mEq. or that she has a total deficiency of about 800 mEq. of body sodium. Remembering that one gm. of NaCl equals 17.2 mEq of sodium, we find we may need to replace 40 gms. or more of NaCl. A rough approximation of the deficiency as shown by these calculations is to assume a serum deficiency of one mEq of sodium means a total body deficiency of one gm. of NaCl.

Obviously, it will be impossible to replace 40 gms. of NaCl by mouth, especially in a patient already anorexic and nauseated. Five liters of normal saline would contain about 43 gms. of NaCl, but the accompanying 5000 ccs. of fluid would be far too

much to give. The obvious solution to this is to use concentrated or "hypertonic" saline and such is the treatment of choice. If we use 5 per cent saline, a large quantity of salt with minimal quantities of fluid can be given quickly. For instance, 200 ccs. of 5 per cent saline will contain 10 gms., of 172 mEq of NaCl, more than the amount of salt contained in one liter of normal saline, yet with only one fifth the fluid volume. Such a patient as we have presented above might then be given 400 ccs. of 5 per cent saline with 40 mEq. of potassium chloride (3 gms.) added to the bottle, slowly in the morning, and an additional 400 ccs. later in the day. The potassium chloride will replace any possible deficiency of this ion occurring with the loss of sodium. This will replace 40 gms. of NaCl and 6 gms. of KCl and will often result in the most dramatic improvement, a patient who was comatose and anuric in the morning, often becoming alert and showing excellent diuresis later in the day.

Particular care should be used not to infuse the hypertonic saline so fast that the whole blood stream becomes hypertonic, since this will result in too rapid return of fluid from the cells, the ensuing hypervolemia elevating venous pressure and ending in acute congestive failure. No harm results from otherwise slowly elevating serum electrolytes to normal, even in the face of pulmonary edema. Continual severely hypotonic circulating fluid is much more lethal than the more obvious and dramatic manifestations of congestive failure which may coexist and which may be thought to be a contraindication of the use of hypertonic saline. The more salient features of these two conditions are summarized in Table 1.

TABLE I.

	<i>Hypochloremic Alkalosis</i>	<i>Low Salt Syndrome</i>
Serum Chloride	low	low
Serum CO ₂	inc.	normal or low usually not inc.
Serum Sodium	normal	low
Tonicity	normal	hypotonic
Rx	N. Saline or NH ₄ Cl	5% Saline (given slowly)
Prophylaxis	NH ₄ Cl and/or normal sodium in diet during mercurial diuresis in both conditions.	

Pamphlets Available

"Returning Cardiacs to Work", a guide for private physicians, is currently being distributed by the Georgia Heart Association to all doctors in the state. If you should not receive a copy write for one to the Georgia Heart Association.

"The Cook Book for Low Sodium Diet" which has been available to patients on their physician's request for the past year will shortly be superseded by a new diet booklet "Food for Your Heart" covering nine diets for varying levels of sodium restriction and calorie intake. Copies may be ordered from the Georgia Heart Association.

Other pamphlets available are: "Examination of The Heart," "Recommendations for Human Blood Pressure Determination by Sphygmomanometer", and "Rheumatic Fever" (a condensed reference work).

Prognosis in hypochloremic alkalosis is excellent, but is not nearly as good in the low salt syndrome. As might be expected, changes of recovery are considerably improved by prompt recognition and vigorous management of this catastrophe. We have found that those patients who are in frank congestive failure when the low salt picture develops seem to respond more poorly to treatment than others, and it might be well to accept some congestion and edema rather than to produce a hypotonic extracellular fluid with all of its consequences.

Summary

A number of conditions have been presented in which a low serum concentration of sodium is found, and the control of the tonicity of the body fluids is briefly reviewed. Those conditions producing a low serum sodium concentration with normal cellular osmolarity show signs and symptoms of electrolyte depletion or the "low salt" syndrome and need urgent treatment. The differentiation of hypochloremic alkalosis and the low salt syndrome is emphasized, since each requires different, and specific therapy. The rationale of treatment is outlined.

Fifth Annual Meeting Notice

The Fifth Annual Meeting of the Georgia Heart Association has been scheduled for September 4-5

at the DeSoto Hotel in Savannah. Scientific Sessions and speakers will be announced at a later date.

Does EXERTION *Precipitate*

CORONARY THROMBOSIS?

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Under the Workmen's Compensation laws of this and most other states, when a man dies at work from coronary thrombosis, and when it is established that exertion precipitated the attack, then the employer is liable for this man's disability, or his death, as the case may be. The relation of exertion to coronary thrombosis then is a question of great medico-legal importance and a review of this question seems timely.

While this paper is concerned with coronary thrombosis it seems wise in the beginning to call attention to the fact that myocardial infarction can occur without actual coronary thrombosis, and that this type of myocardial infarction can result from exertion. In this case a person with coronary disease while engaged in exertion experiences angina. If he ceases his exertion the pain passes off in a few minutes and no damage is done to his heart. If however, circumstances are such that he continues with the exertion after the onset of angina, then there may result such a circulatory deficit to a portion of his myocardium that an actual infarct occurs. These cases are not difficult to recognize clinically as there is always the history of continued exertion after the onset of angina. An example of this occurred in one of my own patients. This man, a policeman, was involved in a fight while attempting to arrest a Negro thug. Shortly after the onset of the fight he began to have angina. Had he been able to stop at this point he probably would have been alright, but he was forced to continue the fight. The result was that after the thug was subdued the policeman was taken to a hospital and examination there revealed unmistakable evidence of myocardial infarction. This of course is an entirely different picture from coronary thrombosis. In coronary thrombosis there is a sudden onset, with or without exertion, and the symptoms persist though the individual may cease his activity.

While coronary thrombosis actually means the plugging of a coronary vessel with a blood clot, the term is used when sudden plugging of the vessel may occur in one of three ways. These are: the formation of a clot over an atheromatous plaque; a hem-

orrhage under the intima which occludes the vessel; and rarely, the plugging of a vessel with cholesterol due to a rupture into the lumen of a subintimal pocket of this substance.

It is an established fact that hemo-concentration, slowing of the blood flow, or any factor which makes the blood clot quicker, will favor the formation of thrombi in the coronary or any other artery. It seems impossible however, that exertion could in any way precipitate the formation of such a clot. On the contrary, the present practice of early ambulation in certain conditions has caused a decided decrease in thrombotic and embolic phenomena.

The plugging of a coronary vessel due to subintimal hemorrhage was first described by Wartman.⁵ He found this condition in 14 per cent of 41 cases of clinical coronary thrombosis. The subintimal hemorrhage was due to rupture of a subintimal capillary and not to rupture of the intima itself. It is felt by some that exertion causes enough elevation in pressure in these capillaries to precipitate rupture. To me this seems unlikely. The work of Winternitz⁶ supports this conclusion. Winternitz injected dye into sclerotic coronary arteries at pressures ranging from 500 to 1000 mm. of mercury without producing rupture of the capillaries. This pressure is of course several times greater than would ever be experienced in life.

Plugging of a coronary artery by rupture of a cholesterol pocket was first described by Leary.³ While this is an unusual condition it does occur in some cases of clinical coronary thrombosis. Leary felt that the rupture of these pockets was due to erosion of the intima over the pocket. He attributed this process to disease and made no mention of it being precipitated by exertion.

The opinion of clinicians as to whether or not exertion precipitates coronary thrombosis is divided. Those who feel that exertion is a factor base this opinion on the fact that some cases are due to subintimal hemorrhage, and, upon statistical studies which have shown that a large per cent of attacks of coronary thrombosis occur while the person is engaged in some sort of activity. As to

Read before the Section on Internal Medicine at the One Hundred Second Annual Session of the Medical Association of Georgia, May 13, 1952.

subintimal hemorrhage this was discussed a moment ago and needs no further comment. In the statistical studies of various authors regarding the relation of exertion to coronary thrombosis no differentiation of coronary thrombosis from myocardial infarction without coronary thrombosis was made.^{1,2} This led to erroneous conclusions about coronary thrombosis alone. Some of the conclusions drawn by some of these authors merit criticism but unfortunately my time will not permit that. However, the belief that exertion precipitated coronary thrombosis was due simply to the fact that a large per cent of the attacks occurred while the person was engaged in some activity.

The other side of the picture has been well presented by Master and associates.⁴ They brought out the point that moderate exertion, emotional conflicts, and at times strenuous exertion, are a part of every day normal living. They felt that when the pathologic process in the coronaries reaches a certain point thrombosis will occur, and in normal living the sudden onset of the attacks will strike a large per cent of persons while they are engaged in some activity. In a report of 1440 attacks of coronary thrombosis their conclusions were: "Detailed histories of the activities and emotional states of patients for hours, days, and weeks preceding the attacks, confirms the belief that physical activity and excitement are not factors in the onset of coronary occlusion."

I was formerly of the opinion that exertion might precipitate attacks of coronary thrombosis but as more light was thrown on the subject this seemed improbable. My interest in the matter prompted a study of 100 cases of my own. A detailed history was taken as to the activity preceding and at the time of the attack, also the time of day of the attack. I was particularly curious to know if the activity at the time of the attack departed in any way from the persons normal activity for that time of day on that particular day of the week. The study was made of 100 attacks, occurring in 96 persons; four had two attacks. In making this study some of the pitfalls of such a study were obvious for some of the patients were quite insistent that some exertion precipitated the attack. Questioning however revealed that the exertion in most instances was not unusual, that at times it occurred hours before the attack, that there was no discomfort during the exertion, and that actually the attack came on while the patient was at rest. The results of this study revealed that the attacks occurred: with usual activity for that time of day (97) with unusual exertion.³

Of those in whom the attack occurred while engaged in normal activity, 33 were in bed resting, and 20 of these were awakened out of a sound sleep. The attacks were evenly spread over the 24 hour period, just as many occurring at night as did during the daytime.

In the 97 cases with usual activity it was all normal activity and there was no

strenuous exertion. This activity included: at work but not engaged in any strenuous exertion, ordinary walking, leisurely walking, driving a car, riding in a car, getting out of a car, playing cards, sitting in a movie, sitting in church, eating, sitting listening to the radio, lying in bed resting, sleeping, mixing high balls for guests, two were in the bathroom and one was on the way to the bathroom. It is obvious that all of this is normal activity in every day living.

The three that were engaged in unusual exertion deserve further comment. One was lifting a heavy object out of his car when the attack occurred. Although he did this about once a week it was classed as unusual exertion. Six months later he had a second attack that came on at 2:00 a. m. and awakened him out of a sound sleep. Another was on his vacation and was walking up a steep grade when the attack occurred. This was unusual for this man did not do much walking in his normal daily routine. However, he had a second attack nine months later at 3:00 p. m. on a Saturday afternoon while lying in bed listening to the radio. The third had his attack about 10 minutes after he had engaged in a rather heated argument. In talking to the patient and to his family I learned that heated arguments are a part of his daily routine.

Some observers have stated that more attacks come on during the working hours. I arbitrarily chose the hours from 7:00 a. m. to 7:00 p. m. as working hours and the hours from 7:00 p. m. to 7:00 a. m. as leisure hours. Fifty-four of the attacks occurred during the working hours and 46 during the leisure hours. These figures indicate that the attacks were evenly divided between the working and leisure hours for in some instances the attacks occurred around seven o'clock and the patients could not tell me on which side of seven o'clock they occurred.

These findings concur with those of Master and strengthen the belief that attacks of coronary thrombosis will occur at any time day or night, and in no way are related to the person's activity or emotional state at the time. Until there is definite evidence that exertion precipitates an attack of coronary thrombosis, and it is doubtful if there ever will be, one is not justified in stating that any attack of coronary thrombosis is precipitated by exertion.

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DISCUSSION

DR. L. MINOR BLACKFORD (Atlanta): Dr. Richardson's paper is both interesting and thought-provoking. He and I have argued this question before, and I welcome the opportunity to do so again in public.

There are still those however, who feel that effort or excitement may provoke coronary thrombosis, Masters, Dack and Jaffe's figures to the contrary notwithstanding. Carter Smith, for example, reported that 32 out of 53 of his cases

were definitely precipitated in this way. I concur in Friedberg's opinion:

Unfortunately such studies (as Masters, Dack and Jaffe's) may be invalidated by the nature of the pathology of coronary occlusion. Although the characteristic symptoms of acute coronary occlusion usually develop suddenly, the underlying pathologic process and functional disturbances associated with the occlusion may commence hours or days before the symptoms appear. Sometimes there are premonitory symptoms during this period which are forgotten by the patient in the throes of the more intense symptoms of the full blown attack. Not infrequently the patient denies any unusual effort prior to the occlusion, but questioning a friend, relative or business associate discloses some extraordinary or dramatic activity which might have been casual. Since the actual occlusion precedes the striking symptoms of the attack by hours or days, the factor responsible for the occlusion may have acted hours, days or even weeks before the appearance of symptoms. Therefore efforts to discover the precipitating cause by recording events or activities immediately preceding the first major symptoms of an acute occlusion may be misleading.

In the last three coronaries in my practice who became acutely ill at rest it was not hard to discover the strain before they rested: in two it was mental, in the third physical: two had had precordial discomfort hours or days before the severe attack.

Winternitz' classic studies revealing the frequency with which the process begins with subintimal hemorrhage are well known. Such hemorrhages would appear to me usually to result from strain.

From Friedberg again: "While the evidence adduced by Masters and his associates might indicate that physical exertion is not an essential or even an important precipitating cause in most cases of coronary thrombosis, it does not exclude the possibility that it induces at least some of the instances of coronary thrombosis."

Since Dr. Richardson has specified that he is talking about industrial cases, i. e., men who fall dead while at work, and since few such cases come to autopsy, the real problem is, as I see it, was the work the precipitating cause. This entitles us to approach the question from another angle.

Since the days of Heberden, angina pectoris has been defined as pain at first brought on by exertion or excitement and relieved by rest; and such persons are notoriously subject to sudden death. It is also true that 30 per cent or more,

of the persons who die suddenly do not show extensive acute thrombosis. However, 90 per cent of sudden deaths occur in persons with badly sclerosed coronary arteries, and nine per cent in those with severe valvular heart disease. In the sclerotic cases studied in detail by Blumgart and Schlesinger, old infarctions, often small, often multiple, were found.

Here is my understanding of such cases. Since Keefer and Resnik's paper in 1928, I think it has been pretty generally agreed that angina represents the cry of the heart for more oxygen to meet the demands of the moment. In the very large majority of cases, probably in all except when an exceedingly rapid rate or valvular disease is present, there is extensive coronary sclerosis and the heart's supply of oxygen is at no time thoroughly adequate though, granted again, in many cases the crudities of the electrocardiogram fail to reveal the ischemia.

As early as 1881 Cohnheim found that ligating a dog's coronary artery often produced ventricular fibrillation, and this fact has been confirmed by many observers in the intervening 71 years. Levine once had a patient attached to an electrocardiograph during an attack of angina: the first lead was not remarkable, but in subsequent leads ventricular fibrillation was evident. This observation too has been repeatedly confirmed.

I believe, therefore, when a man free from valvular disease drops dead while engaged in physical activity or in emotional stress and autopsy shows no fresh infarction of consequence, that coronary sclerosis will be found, that the activity or excitement of the moment had increased the demands of the heart for oxygen, which was not forthcoming, and that the anoxia resulted in ventricular fibrillation; and indeed, even in cases of recent thrombosis, that the terminal event is often ventricular fibrillation.

Now I am not defending the Compensation Law as at present interpreted. If death or injury result from failure of the employer to provide adequate safeguards for the protection of his men, I think we will all agree that he should be liable. However, when an employee has over the years developed coronary sclerosis, and the work he is engaged in just preceding death is like the last straw that broke the camel's back, it hardly seems fair to make the employer pay. Even more important, while the payment helps that particular man's widow, it increases the difficulty, already great, of other middle-aged men in landing a job.

Finally, I cannot imagine any doctor allowing a patient who knows he has considerable coronary sclerosis to indulge in unlimited activity, emotional or physical.

PRESS COMMENT: *In Any Language*

Some time ago the head of the American Medical Association said, "We begin to hear that the government's compulsory health insurance plans are not socialized medicine. That's ridiculous. Any plan supported by taxation of the people in which the rules are written by government bureaucrats who also determine the fees is socialized medicine in any intelligent person's language."

It's the old story of the camel who stuck his nose under the side of the tent. Before long he worked his whole body into the tent and took up all the room. That's the way socialism works. Attractive phrases may be used in an effort to camouflage it, but the result is always the same—more and more political domination of our lives, and less and less freedom and opportunity and incentive for the indi-

vidual.

In the case of medicine, moreover, socialization, as we have witnessed it abroad, has in many cases resulted in very serious declines in the standards of medical care. Regimented doctors, bound to follow the rules laid down in a politically-written book, aren't progressive doctors. And the costs to the taxpayers have been staggeringly high.

The last election was a victory for those who believe in freedom and it was a setback for the socialists in and out of government. General Eisenhower opposed socialization of medicine. But that doesn't mean the issue is dead. It will keep on arising, in one guise or another. The socialist camel never stops trying to get his nose under the tent.

SCREVEN COUNTY NEWS

INTRACTABLE HEART FAILURE

LOUIS K. LEVY, M.D., Atlanta

It is extremely difficult to define specifically the clinical term *intractable heart failure*. In general, it is applied to cases of congestive cardiac failure which do not respond to the usual therapeutic measures. However, this does not mean that the condition cannot be alleviated. In far too many instances the patient is considered to be a "burned out cardiac" or to have "no cardiac reserve." No matter how ingenious the efforts, a certain percentage of the cases of failure will, of course, fall into these categories, but it is obligatory that each patient be carefully evaluated and given the benefit of every logical therapeutic approach before such a conclusion is reached.

By careful selection of the proper therapeutic measure, or combination of measures, and their administration to the limit of the patient's tolerance, many of these cardiac cripples can be salvaged for additional weeks or months of worthwhile existence. In such a program, which frequently requires heroic measures, it is important to detect the first signs of improvement and also the earliest symptoms of intoxication. The patient's weight, venous pressure determinations, and to a certain extent, studies of circulation time are important in evaluating the efficacy of therapy for congestive heart failure. Whereas it is generally feasible to weigh the cardiac patient daily, it often becomes necessary to rely on determinations of venous pressure and circulation time in order to follow the progress of the illness. Venous pressure must be measured while the patient is in the supine position. Weight and venous pressure decrease concurrently in diuresis,¹³ but there is a tendency for venous pressure to start to drop before there is a decrease in weight.⁸ This fact is of importance in intractable failure when it is often necessary to push therapeutic measures to the limit and employ the finest methods to gauge results in order to avoid serious toxic effects from potent agents.

Correction of Extracardiac Precipitating Factors

Extracardiac factors are sometimes important etiologically or may precipitate or prolong heart failure. The finding and correction of such factors will at least alleviate and, in certain instances dramatically terminate, failure.

Every patient with auricular fibrillation should be suspected of being a masked thyrocardiac, especially if larger than usual doses of a digitalis preparation have been employed with limited success. It is also entirely possible for a marked hypothyroid state to lead to congestive failure when other manifestations of myxedema are not grossly evident.

Correction of the medical disorders of anemia and beriberi will have a most gratifying effect upon the cardiac state. Enlargement of the prostate or any obstructive lesion of the urinary tract will often further congestive failure and should be treated. Not only do urinary tract infections adversely affect heart failure but they also add to the danger of using mercurial diuretics.¹²

Surgical Correction of Cardiac Factors

Constrictive pericarditis, which should be suspected when the patient has marked ascites and only slight edema of the legs,¹ will respond dramatically to surgical measures. Spectacular results, of course, can be achieved by correction of an arteriovenous fistula.

Drugs Affecting the Heart

Digitalis. The digitalis preparations are the outstanding drugs used to increase cardiac efficiency. It is mandatory that the physician have a thorough knowledge of this group of drugs, for he must be prepared to push dosage to the limit. Although digitalis and its derivatives have been in use off and on for about two hundred years, it is only in the past decade that the extreme variability in dosage requirements from patient to patient has been recognized. The digitalizing dose ranges from five to 40 cat units and the maintenance dose varies from two cat units per week to two cat units per day.⁴ This

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means that rule of thumb methods must be discarded when doses are calculated for patients with intractable heart failure who particularly need the maximum effect of these drugs.

On the other hand, in the presence of acute necrotic lesions or of acute inflammatory disease, such as rheumatic fever, pushing digitalis to the limit may be dangerous. In high output heart failure, as in severe anemia or in emphysema of marked degree, digitalis is without appreciable effect and may even reduce the output of the heart.

An individual who is on a greater than average maintenance dose of digitalis and who develops increasing congestive failure without apparent cause should be suspected of digitalis intoxication. As a rule, other evidences of toxicity are present besides the advancing congestive failure,³ but they may be so few and minor that they are not readily apparent.

Quinidine. If the possibility of hyperthyroidism has been eliminated, serious consideration must be given to the use of quinidine when auricular fibrillation with a rapid ventricular rate is present in intractable heart failure. This is true even though there is marked electrocardiographic evidence of myocardial disease.

Rest

In the treatment of intractable failure, adequate rest in every form—mental, physical and digestive—must be enforced.

Sedatives. The free use of morphine or demerol may, because of their antidiuretic effects, counteract the desired action of the mercurials.

Oxygen. Oxygen is an excellent adjunct and should be used whenever reasonable doubt exists as to its probable effectiveness.

Thoracentesis

The dramatic relief of dyspnea following the removal of relatively small amounts of fluid from the chest justifies a most thorough search for effusion. Lateral⁶ as well as posterior-anterior roentgenograms and fluoroscopic studies are indicated when clinical judgment points to unverified pleural effusion. Occasionally, a diagnostic thoracentesis will reveal the presence of fluid when all other methods fail.

Regulation of Fluid Intake

The average patient with congestive heart failure should be allowed to drink water as desired, thereby consuming enough to maintain a daily minimum urinary output.¹⁰ The amount of water needed varies inversely with the concentrating power of the kidney. In congestive heart failure, kidney function is impaired, as indicated by the presence of protein, red blood cells and casts in the urine. The blood urea nitrogen is normal. The blood sodium and chloride are either at the lower limits of normal or slightly below normal. If the water intake is inadequate, more protein, casts and red blood cells appear in the urine and the specific gravity rises to 1.025 or higher. Hypertonic dehydration of the blood appears, characterized by a rise in urea nitrogen and an increase in the sodium and chloride to the upper limits of normal or even above normal. In the older individual

with arteriosclerotic kidneys, the blood urea nitrogen may rise above 100 mg.¹² Uncorrected hypertonic dehydration produces refractory heart failure. This situation demands more water and other methods of promoting sodium diuresis. In the presence of intrinsically impaired renal function, sepsis, excessive skin or urinary water loss, fluid intake should be increased to prevent dehydration.

On the other hand, in severely ill cardiac patients an unduly high fluid intake may result in excessive hydration and renal insufficiency. It may become necessary in some cases to measure the levels of plasma sodium, chloride and carbon dioxide-combining power in order to know the degree of hydration.

The treatment of the failing heart in renal insufficiency does not differ from treatment of congestive failure from other causes, but is generally less successful.¹⁴

Control of Diet

The serum albumin tends to be low in patients with chronic congestive failure⁹ and a low level of the plasma protein may be responsible for the patient's failure to respond to the usual therapeutic measures. If significant hypoalbuminemia becomes established, heart failure may remain refractory to all treatment including intravenous albumin, plasma or blood.¹² Every effort should be made, therefore, to keep the blood proteins at a high normal level because it is extremely difficult to correct the deficit after it has occurred and consequently the heart failure is almost completely refractory. To maintain a high normal blood protein, high protein diets should be employed routinely in congestive failure with peripheral edema.

Salt intake must be carefully supervised for some patients will lose edema when the salt intake is 1.0 gm. per day and gain it when intake is only 2.0 gm.¹¹ A minority group, which generally is composed of intractable failure cases, require restriction of salt to 0.5 gm. per day.

Diuretics

Diuretics have their greatest value as supplementary measures when other means, such as proper digitalization and dietary control, are insufficient for complete control of the signs and symptoms of myocardial failure.

Mercury. The mercurial diuretics are the most powerful and rapid sodium-eliminating drugs. Intractable heart failure may become established when these drugs are not used boldly enough.¹² Occasionally the kidneys do not respond at first. The drug may be repeated provided there are no unavoidable and undesirable side effects. The response is considered adequate when the urinary output is above 2500 cc. or when the patient loses two pounds or more per day. The predictability and degree of diuresis depend upon many factors besides the preparation used, dose and route of administration. Important also are the severity of the underlying heart disease, the amount of edema, the presence of ascites, which presumably exerts extrarenal pressure, hypochloremia, hypoproteinemia, status of kidney

function, administration of acidifying salts, amount of physical rest at the time of onset and peak of diuresis, and degree of digitalization. Inadequacy in the last three factors explains most diuretic failures.²

In patients who respond poorly to mercurials, a remarkable increase in diuresis often can be obtained by the administration of six to 12 Gm. of ammonium chloride daily in divided doses for two to four days preceding the mercurial injection. However, administration of ammonium chloride over long periods of time is of doubtful value, and if renal ischemia is marked, large doses may result in severe acidosis. Ultimately, in chronic congestive failure, poor response to mercurials may occur despite pretreatment with ammonium chloride. Aminophylline may potentiate the action of mercurials by causing a significant increase in the glomerular filtration rate which may persist for an hour or so after the injection. It is best to give slowly 0.5 Gm. of aminophylline intravenously⁷ 60 to 90 minutes after the injection of the mercurial, at which time the effect of the mercurial is maximal. Good diuresis in patients previously resistant to mercurials has been obtained by this procedure.

Another way to increase the effectiveness of the mercurials is to keep the patient at rest in bed after the injection.

In properly selected cases mercurial diuresis may be used for prolonged periods without producing renal or other damage, as proven by autopsy studies. Toxic effects are manifested by a rapidly rising blood urea nitrogen in the absence of hypertonic dehydration, rather than the expected fall.¹² This occurs when the mercurial is used in the presence of acute inflammatory nephritides or when it is used repeatedly in spite of a diminishing response by the kidneys. It is difficult to evaluate nitrogen retention in the patient taking mercurial diuretics. In general, if the non-protein nitrogen exceeds 60 mg., these agents should be used with extreme caution. However, the danger of renal damage from frequent injections has been much exaggerated.¹⁴ Elevated blood urea nitrogen and creatinine levels alone are not necessarily pathognomonic of renal damage but may be concomitants of extensive diuresis and salt loss. Mercurial nephrosis occasionally occurs as a result of excessive dosage in an unresponsive patient. If albuminuria, hematuria, or oliguria appears, when previously absent, the drug must be discontinued.

The physician who is prescribing diuretics must be on the alert for the salt depletion syndrome which leads to refractoriness of the congestive failure plus weakness, lassitude, anorexia, nausea, vomiting, restlessness, dyspnea, clammy skin, high non-protein nitrogen and, of course, low blood chloride levels. Potassium depletion may complicate the low salt syndrome¹⁴ and it should be remembered that therapeutic administration of potassium salts should not be undertaken without frequent electrocardiographic observations and determinations of serum level and urinary output of potassium.

Many problems in the field of electrolyte and water metabolism in congestive heart failure are still

unsolved and require elucidation for a clear understanding of this condition.

Exchange Resins. Unquestionably the chief field of usefulness of the exchange resins is in intractable congestive heart failure, but their administration is not without considerable danger.¹⁵ Impaired renal function is the outstanding contraindication to their use. They tend to produce low salt syndrome, azotemia, and mild to moderate transient acidosis. It is inadvisable to administer exchange resins to patients who are not eating reasonably well.

Production of Hypothyroidism

For a number of years intractable congestive failure has been treated with varying degrees of success by the deliberate production of hypothyroidism in patients of euthyroid status. At first, this was accomplished by surgical intervention, but in recent years the same reduction in functioning thyroid tissue has been produced by the use of radioactive iodine.⁵ This procedure may alleviate the dyspnea, orthopnea, and edema of congestive failure. Final evaluation of this therapy, however, must await prolonged study. At present, it can be said that many months of worthwhile existence have been added to the lives of numbers of disabled cardiac patients who were refractory to all other forms of medical therapy. It is, however, sometimes difficult to balance the effects of myxedema against those of congestive failure.

Conclusions

A number of approaches to the treatment of intractable heart failure have been presented. The practical importance of adopting an inquisitive, rather than a defeatist, attitude toward this condition and initiating positive and thorough action promptly cannot be overemphasized.

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DISCUSSION

DR. ERNEST F. WAHL (Augusta): I wish to point out that Dr. Levy has emphasized the necessity of studying the

patient in great detail. In this way factors may be brought to light which contribute to the heart failure and if corrected will remove that case from the class of intractable heart failure. Dr. Levy has discussed the many phases of the management of these cases and I am unable to add any further suggestions. I have always been puzzled by the fact that we have heart failure in unrecognized hypothyroidism and on the other hand occasionally benefit a patient in heart failure by producing hypothyroidism by surgery or radiation. It seems to me that we are drawing a very fine line in some of these cases. Unfortunately regardless of the physician's skill we still encounter patients with heart failure who are unable to respond to any therapy.

Prognostic and Therapeutic Implications of

CLASSIFICATION *of* HYPERTENSIVE DISEASE

ELLISON R. COOK, III, M.D., Savannah

I would like to bring to the attention of my fellow practitioners a few well known facts concerning hypertension and hypertensive disease. There seems to have been a recent minor wave of hysteria emphasizing drug and dietary treatment, but no emphasis on what is being treated. Hypertension might be a sign of many diseases, or it may represent no disease process whatever. The so-called standards for normal blood pressure purport only to be averages for groups of people apparently at the time in good cardiovascular health, and by no means can be considered a limit to normal variations. The "snuzzle" of Cyrano was certainly unusual, but was it abnormal? As a matter of fact, this edifice served him quite well in the usual functions of a nose, but occasioned comment because of a characteristic not related to function. May this not be analogous to our reaction to a sphygmomanometric reading? We marvel at the height of it, yet frequently fail to notice the more important factor, the functional capacity of the cardiovascular system. Are we cutting off the nose despite the face?

True, hypertensive disease is a vicious killer, one of our worst. Would that we had a weapon to di-

rectly attack it, rather than being forced, as we are, to attempt symptomatic obstruction of some of its varied effects. This is not intended as professional self censure or humility. We should be proud of doing so well when we are only on the threshold of understanding of the basic processes involved. However, one little battle won is constantly and repeatedly being interpreted by some as utter defeat of the enemy.

If we have found a weapon that is effective against an enemy, then we have come a long way toward the understanding of the nature of the enemy if the effectiveness is properly interpreted. But we stand in danger of interpreting effects against a satellite or a camouflage as effects against the aggressor, thus misinforming ourselves and stockpiling the not quite right weapons. To go back and recapitulate is a step forward, if we have progressed too far in the wrong direction. What then, are the recognizable clinical features to you and me of the hypertensive group of diseases?

First, the blood pressure is high. By this we generally infer the diastolic reading to be above 90 millimeters of mercury. Higher readings do not necessarily indicate the presence of a cardiovascular abnormality, but generally, under basal conditions this may be taken as a fair approximation. The height

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of the increment above this figure does not appear to correlate with the severity of the disease. There is some indication that the average normal blood pressure may be a bit lower than we have thought, especially in young people.

Second, there are vascular changes. The basic changes seem to be constriction of the arterioles, or changes in flow through metarterioles into the capillary bed. On the clinical level, this is only demonstrable in the retinae, and evaluation of the changes is subject to wide variations due to difference in opinion, background, training, eyesight, persistence, and type of classification used. However praiseworthy their motives of establishment were, we have retreated by our lazy natures to the protection of numbered classification. It is here proposed that accurate detailed word descriptions of all visible arterioles be considered an integral part of hypertensive disease classification.

Third, the heart is affected. Compensation must be made for the increased load applied. The compensatory factors as we can detect them clinically are hypertrophy, tachycardia, and dilation. Unfortunately, minor variations in these are not easily detectable. Though more accurate means of measurement are desirable, this does not preclude the means we have at hand. Exercise tolerance tests may have been omitted because of inconvenience, but can frequently, even when applied to pulse rate response alone, indicate previously subclinical lack of adaptability. The admittedly crude but still quite useful methods of percussion and auscultation to detect hypertrophy and dilation may and should now be routinely supplemented by fluoroscopy in all views. Frequently the accuracy of these observations may be obscured by skeletal deformity, residua of previous infectious lung and pleural disease, and the very common dyspneic abnormality of later life, emphysema. More information may be obtained from determination of circulation times and venous pressure, with and without liver pressure, these being easily performed office procedures. The electrocardiogram, finally, gives evidence of myocardial strain and/or hypertrophy.

Fourth, the kidneys must be considered. Evidence has continued to accumulate since Dr. Bright's first observation that here may be the basic patho-

logical physiological alterations of the disease process; be it enzymatic, hormonal, or mechanical. But on a clinical level, we are here poorest of all in usable evidence to evaluate the presence or severity of the disease process until it has progressed far beyond the stage in which we would like to institute procedures for modification. However, the presence or absence of hypostenuria, impaired phenolsulfonphthalein excretion, albuminuria, microscopic formed elements, and nitrogen retention must be noted, and their relation to this or other disease processes established.

Many other procedures have been proposed and are frequently of value in evaluation. Even though the above oversimplification is certainly elementary, it represents the clinical factors generally available for classification. It is to be hoped that their recapitulation will lead away from the ivory tower and toward a more realistic appraisal of situations presented in practice. This is not intended to scorn the tower or its inhabitants, but to form a firm basis of understanding of our mutual enemy, so that we may all be victorious more often in minor skirmishes, thus contributing more to evaluation and leading toward ultimate complete victory.

It is therefore proposed that, before any treatment or prognosis be attempted, the following facts as minimum be visually recorded:

1. Sphygmomanometric readings erect, sitting, and supine, initially and after relaxation, and where indicated by other findings, in both arms and a leg.
2. Description of the retina, optic disc, and especially the retinal arterioles.
3. Fluoroscopic observations.
4. Abnormal physical findings and simple functional tests of cardiac compensation.
5. Urinary findings.

In addition, other procedures are recorded as indicated.

In this way, the hypertensive disease process may be classified by its demonstrable effects and treatment and prognosis directed accordingly. We find in our clinic and practice that most people with an elevated blood pressure reading have no evidence of disease by these criteria, and thus by our standards, do not need nor should they be given treatment of any kind. By treatment we include the overworn phrase, "take it easy and come back in a few weeks and we'll see if that little old blood pressure has come down." The person least likely to take advice and most likely to worry about it is the person with functional vasomotor instability, and iatrogenic psychic and/or vascular disease is not easily defensible.

We find further that many patients without vascular disease have become victims of attacks upon their blood pressure. A drug effective in reducing blood pressure must of necessity have generalized strong action, and thus is easily toxic. Surgery of any form is a near catastrophic event in the lives of most people. Let us be sure, therefore, that disease be evaluated against any proposed treatment so that the disease and its prognostic implications are always less desirable than its alleged cure.

The Place of the

CARDIAC CLINIC *in Relation to the*

PUBLIC HEALTH PROGRAM

of Heart Disease Control

Only in recent years have the problems of the chronic diseases, and particularly those of the cardiovascular diseases, been viewed in the light of public health. These diseases pose problems far more difficult than the acute communicable diseases and thus offer the greatest challenge that public health workers have ever faced. Due to our aging population, the problem is growing day by day; in both morbidity and mortality the trend is upward. During 1950, 47 per cent of the deaths from all causes in Georgia were due to the cardiovascular diseases. This is an increase of approximately 1.5 per cent over the 1949 figure.

Although mortality figures are of some value, they do not give us much insight into morbidity. In an effort to arrive at some idea of the size of the problem, I appealed to Mr. A. P. Iskrant, Division of Chronic Disease and Tuberculosis of the U. S. Public

Estimated total prevalence of c-v in U. S., 1949.....	9,200,000
Estimated number of cases of c-v diseases in Georgia.....	172,000
Estimated distribution by color:	
White	103,000
Non-white	69,000
Estimated distribution by sex:	
Male	100,000
Female	72,000
Estimated distribution by type of cardiovascular disease:	
All c-v diseases	100% 172,000
Diseases of the coronary arteries and angina pectoris. (Acute endocarditis, excluding rheumatic)	27.1% 46,612
Chronic affections of the valves and endocardium and other chronic rheumatic heart diseases	13.4% 23,048
Myocarditis (all forms, excluding rheumatic)	51.9% 89,268
Other	7.6% 13,072

Director of the Division of Heart Disease Control, Georgia Department of Public Health.

Health Service. I should like now to quote from Mr. Iskrant's letter:

We hesitate to estimate prevalence in Georgia because of obvious inadequacies in available figures. However, knowing your need for some type of local statistics, we have made rough estimates of the prevalence of cardiovascular diseases in Georgia by color, sex, and type of disease. I need hardly mention that these are rough estimates that may be of some use in general definition of the problem, but should not be presented as having been obtained with any degree of precision.

When we have some idea, more or less, of the extent of the problem, we tend to become appalled and to ask: what can we do about it, anyway? Our knowledge is limited, to be sure, but much that is now known never reaches the patient. We cannot and we must not wait. We must make a beginning and in some manner develop public health techniques as scientific knowledge progresses.

Cardiovascular diseases are not only medical problems in the strict sense, they are community problems. They are social, emotional, economic, and vocational problems. Due to the nature of these diseases, the health officer and his staff must become the coordinator of all of the community forces. He should bring together all agencies, both official and non-official, in planning his attack and evaluating the resources available to him. In this way the problem can be clearly defined and each group in the community can understand where it fits into the picture and what responsibility it will have to assume. When this has been done, he is ready to set up his cardiac clinic.

Of necessity, the clinic will be the core of the cardiac program, and therefore it should be staffed by well trained and competent personnel. A *must* is a medical director whose training and interest lie in the cardiovascular field.

The first objective of a community cardiac program is to provide *service to patients*. Consequently, we need to find cases; every available method should be employed in order to find them early. Then we need to diagnose and treat in the light of current knowledge. We need to use prevention and prophylaxis in order to stop progression of the disease. We need to develop a home-care program to shorten hospitalization, to follow our cases, and to reduce the cost of care. We must coordinate all community services so that our patients will benefit to the fullest extent.

The second objective should be *educational*. The public should be informed through a constant health education program. The clinic should also serve as a teaching unit for local members of the medical profession, nurses, social workers, and allied professional groups. And the patient should be educated as to the nature of his disease, while the visiting nurse should educate the family as to the patient's care and emotional needs.

The third objective should be to carry on *research* wherever patient load, time, and money will permit.

The Cardiac Clinic at Grady Hospital is such a clinic. Here the local medical profession, working in complete harmony with the State and local health departments, took the lead and have produced a service and a work of which we can all be justly proud. It is our belief that this Clinic has set a pattern, and that nothing short of the services which it renders should be considered adequate.

Since the establishment of the Grady Clinic, other cardiac clinics have been established at Athens, Augusta, Savannah, Macon, Albany, Columbus and LaGrange. Some have a home-care program and some do not. For all but two, visible writing electrocardiographs and fluoroscopes have been supplied by the State Health Department through the local health department. At present, clinics are being formed at Gainesville, Griffin, Thomasville and Waycross, for which such equipment will also be available. Before each new cardiac clinic is recognized as such, it must have the approval of the Georgia Heart Association.

The public, I am sure, does not want socialized or regimented medicine. But in the ebb and flow of the tide, the sentiment for better medical care and better public health is increasing, and at what hour it will reach high tide no one can predict. This sentiment is manifest in the many and oftentimes hastily prepared legislative bills introduced in the Congress in recent years. We do not need legislation, we need cooperation. We need to know what is economically and socially sound. As responsible members of the medical professions, we need to join hands and swim with the tide, not against it. We need to redirect public thinking so that more tax money can be made available for facilities and for indigent care. Uniting with lay and other professional leaders, a program for the health care of all the people can be formulated within the framework of free enterprise. Then, and only then, will the ghost of socialized medicine silently steal away.

District and County Society Program Aid

The Georgia Heart Association always welcomes opportunities to present the scientific sessions at meetings of medical societies or at district meetings anywhere in the state. The Association will arrange for the speakers and, if any preference of topics is indicated, will select speakers for those specific subjects.

Naturally these programs are all on various aspects of heart disease but every effort is made to make them varied and of an interesting and practical nature. Arrangements for speakers or entire programs may be made by writing The Georgia Heart Association, 11 Pryor Street, S. W., Atlanta, Ga.

Progress Report of the

GEORGIA HEART

Association

Through the short years of its organization, it has become the traditional policy of the Georgia Heart Association to report on its activities during the preceding year, its expenditures of funds and the proposed budget for the coming year. This appears in pamphlet form for distribution to members of the association and those who have contributed to its support.

The following items are reproduced here from the current "Annual Progress Report" of the Georgia Heart Association. They are necessarily brief and simplified and do not present in their entirety the wide and comprehensive activities of the association—but they will help to give some idea of what is being attempted and what is being accomplished in this ambitious program to combat heart disease and its effects.

Rheumatic Fever

Gratifying progress has been made in the development of a state rheumatic fever program. Principal impetus in the advancement of the program has been the recognition of rheumatic and congenital heart disease in the category of diseases handled under the Crippled Children's Division. The operation of a children's heart clinic in Atlanta by the division in cooperation with the statewide system of heart clinics developed by the Heart Association now makes diagnosis, treatment, hospitalization and even surgery available to children whose parents would be unable to pay for medical attention.

The program of education of parents and teachers to greater understanding and awareness of rheumatic fever and rheumatic heart disease started last year has been continued—and will be intensified now that adequate facilities for patient care make case finding possible. Professional education on the subject is being intensified with rheumatic fever included as a topic in scientific sessions and nursing institutes and in material published and distributed by the Heart Association.

It is hoped that the next step in the expansion of the program will be the development of close cooperation with school health authorities both for finding cases early in school age children and for the

provision of necessary facilities for the education of convalescent children.

Clinics

The clinic program—considered the backbone of our heart program—continues to expand. In comparison to eight clinics in the state a year ago, there are now twelve. Two of these—in Waycross and LaGrange—have been in operation nearly all year. The other two—Jesup and Thomasville—have opened just recently.

As indicated, these clinics are playing a vital part in making diagnosis and treatment available to rheumatic fever patients in cooperation with the Crippled Children's Division. They are, of course, affording treatment for all other types of heart disease in indigent patients.

These figures compiled prior to the opening of our last two clinics give some idea of the current scope of the clinic program:

Average total number of clinic sessions per month	82
Average total number of doctors participating at one time	31
Average total number of patient visits per month	2911
Average total number of home nursing visits per month	830

Research

Research funds of the Georgia Heart Association are directly supporting projects both at Emory and Georgia. At Emory, a study in the treatment of high blood pressure, necessitating a retinal camera, a fellowship and a technician, has been underwritten for a period of three years. At the Medical College of Georgia, Georgia Heart funds are helping support the cardio-pulmonary laboratory.

American Heart Association funds for nationally sponsored research are also supporting additional projects in both of Georgia's medical schools. At Emory, these AHA funds are providing a fellowship and supporting a study in the vascular response to sodium restriction. At Georgia, a study of the effects

of adrenolytic agents on the cardiovascular system of dogs in the presence of humoral or neurogenic hypertension is supported.

These American Heart Association supported projects are, of course, made possible by the 25 per cent of Georgia Heart funds remitted to the American Heart Association for national research, education and program development.

Medical Symposia and Scientific Sessions

Since the findings—the new methods of diagnosis and management of heart disease—arising from scientific research are worthless until they are put into use . . . it is constantly and increasingly important that all available information on heart disease be passed on to the practicing physician. And, since the practicing physician is notably a busy and overworked individual, the most practical method of doing this is to bring the information to him.

While pamphlets and publications help, the most effective means of doing this has been found to be the presentation of scientific sessions and symposia at the county and district medical society meetings, at our Annual Meetings, and at the Annual Meetings of the Medical Association of Georgia and the Academy of General Practice. This is being done.

While we are not yet satisfied with the extent of this program, still progress is being made. Among current advances are:

A lectureship on heart topics for the Annual Meetings of the Medical Association of Georgia.

A memorial lectureship for Dr. W. W. Daniel created jointly with the Academy of General Practice.

Recognition of the scientific sessions of our Annual Meetings for credit points toward membership in the Academy of General Practice.

Creation of an extensive slide presentation on Rheumatic Fever available on loan to speakers.

Cardiac Nursing Institutes

Our program of providing graduate training in the special demands of nursing in cardiac cases for nurses already practicing was started last year with an institute conducted concurrently with the Third Annual Meeting. The program is continuing and expanding with programs on cardiac care presented in cooperation with public health nurses, nursing associations—and, in one case, at a joint meeting of the 10th District Medical Society and the 9th District Nurses Association.

The 130 nurses reached with the first of these programs last year has grown to nearly 1,000 who have attended these sessions. Publication of a Handbook on Nursing Care of the Cardiac Patient has been delayed by efforts to make the presentation of this complex subject comprehensive and, at the same time, clear and concise. It should be ready in the next few months.

Rehabilitation

The importance of rehabilitating heart patients to

lead reasonably normal and productive lives cannot be overestimated—whether it is the guiding of the education of the young patient so that he may be trained for a job within his limited capacities or returning thousands of employees in business and industry to jobs that will support them and their families.

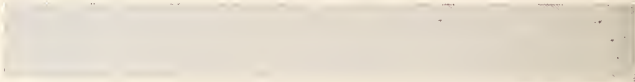
The latter problem is of great economic importance not only to the employee but to the employer who is needlessly losing the services of trained employees in their most productive years. Our Committee on Vocational Rehabilitation is making considerable progress in the groundwork of getting representatives of management and labor to recognize this and work toward solution of the problem. It is also considering the most practical method of making accurate work classification available to Georgia heart patients.

Since the greater number of heart patients are able to work, the greatest single problem remains the existence of obstacles, economic and legislative, to the employment of heart patients.

Georgia Heart Association Funds

This statement is a simple presentation of the actual allotment of funds raised last year, the budget for next year based on the 1953 goal and a visual representation of what this budget means in terms of each dollar contributed.

The 1953 Heart Fund goal is \$150,000. This was also the goal for 1952, but only \$136,991.98 was raised. However, it is anticipated that this year the goal will not only be reached but surpassed—permitting even greater progress in the Georgia Heart program.



	Funds Raised 1952 Actual Allotment	Funds Anticipated 1953 Tentative Budget
*National Research Education and Program Development	\$ 29,904.06	\$ 37,500.00
Local Research	30,731.92	37,500.00
Education, Professional and Public Community Service, Clinics, Re- habilitation, rheumatic fever....	24,544.00	25,000.00
Fund Raising	32,769.00	32,500.00
Administration	11,197.00	10,000.00
	7,846.00	7,500.00
	\$136,991.98	\$150,000.00



*This item represents 25 per cent of the funds raised which each affiliate remits to the American Heart Association to support that portion of the heart program which can be conducted most effectively and economically at the national level.

Report of the

MAG COUNCIL

Meeting, January 11, 1953, Atlanta.

The Council of the Medical Association of Georgia met at 11:00 a. m. with the following present: Drs. H. Dawson Allen (Chairman), David Henry Poer, C. F. Holton, William P. Harbin, Jr., Lee Howard, George R. Dillinger, W. G. Elliott, J. W. Chambers, Marion C. Pruitt, D. Lloyd Wood, Sage Harper, Stephen T. Brown, Enoch Callaway, John W. Turner, Clarence B. Palmer, W. Bruce Schaefer, Frank K. Boland, James Semans, and Messrs. Milton Krueger and Sid Wrightsman, Jr.

The following action was taken:

1. *Approved* advance monthly distribution of the *Journal* to all daily newspaper editors in the state.

2. *Recommended* sale of remaining Association movie projector at estimated resale value to Georgia Division, American Cancer Society.

3. *Instructed* Committee on Medical Defense to include in its annual report more specific details on cases under its jurisdiction which would be of particular interest to members.

4. *Endorsed* proposed "Injunction Bill" for passage in 1953 General Assembly.

5. *Approved* membership comprising the *Journal* Editorial Board.

6. *Authorized* appointment by the President of an Association Building Committee to consider present and future office and building needs of the headquarters office.

7. *Recommended* appointment of District Advisory Committees on Selective Service to replace existing County Advisory Committees.

8. *Accepted* a resolution from the Georgia Historical Commission, for referral to and action by the House of Delegates, which petitioned the Association thusly:

a. To assume all responsibility having to do with the establishment of a Crawford W. Long Memorial Museum at Jefferson, Ga.

b. To appoint a standing committee for such purpose, to be known as the Crawford W. Long Memorial Museum Committee, initial chairman of which would be Dr. Frank K. Boland of Atlanta.

c. To donate the sum of \$10,000.00 for the museum's maintenance, expenditure of which would be directed by the Crawford W. Long Memorial Museum Committee.

9. *Designated* Dr. Frank K. Boland of Atlanta as Chairman of a special Committee on the Crawford W. Long Memorial Museum, additional members of which would be appointed by the President at a future date.

10. *Recommended* utilization by District Medical Societies of scientific speakers available under auspices of the Georgia Heart Association.

The meeting adjourned at 1:00 p. m.

The Association

Report of the HOSPITAL Meeting, January 21, 1953

In attendance at the Subcommittee on Hospitals Meeting held at the Academy of Medicine at 4:30 p. m. were the following: Drs. R. F. Spanjer, Cedartown; H. A. Goodwin, Summerville; R. C. Williams, Atlanta; A. J. Davis, Augusta; E. Lancaster, Shady Dale; and David Henry Poer, Atlanta. Committee Chairman Spanjer presided.

After a discussion of the various aspects of rural hospital problems, it was proposed to sponsor "joint hospital-physician conferences" in various parts of the state. These sessions would concern themselves with a program designed to answer some of the immediate problems facing rural hospitals in Georgia. The programs would be sponsored jointly by the Medical Association of Georgia and the Georgia

Department of Public Health.

It was further recommended that a trial pilot meeting of this nature be held in North Georgia, composed of the seventh and ninth districts. Special efforts would be made to invite the hospital administrator, chief nurse, chief of the medical staff, members of the medical staff, and the presidents of the district and county medical societies covered in this area.

Dr. R. F. Spanjer, Chairman of the MAG Subcommittee on Hospital, and Dr. R. C. Williams, Director, Hospital Services Division, Georgia Department of Public Health, were to meet January 28 to lay the groundwork planning for this sectional meeting. The meeting adjourned at 6:00 p. m.

ANNOUNCEMENTS

FEBRUARY 22: Medical Association of Georgia Conference for Presidents and Secretaries of all District and County Medical Societies to be held at the Academy of Medicine, 875 West Peachtree, N. E., Atlanta, 9:30 a. m.

FEBRUARY 23-25: The Atlanta Graduate Medical Assembly and the Southeastern Section of the American College of Surgeons will meet jointly at the Biltmore Hotel, Atlanta.

FEBRUARY 25: Jefferson County Medical Society will meet at the Jefferson Hotel, Louisville, Ga., at 8:00 p. m.

MARCH 2-5: The New Orleans Graduate Medi-

cal Assembly will hold their sixteenth annual session in the Municipal Auditorium in New Orleans.

MARCH 3: Spalding County Medical Society will hold their monthly meeting at the Spalding County Hospital.

MARCH 5: Fulton County Medical Society will hold their monthly meeting at the Academy of Medicine, Atlanta. Dinner will be served at 6:30 p. m. followed by the meeting at 7:00 p. m.

MARCH 10: Decatur-Seminole County Medical Society meeting.

MARCH 11: Tattnall County Medical Society meeting.

MARCH 12: Habersham County Medical Society will hold their monthly meeting.

MARCH 18: The First District Medical Society will meet in Statesboro.

SOCIETIES

Fulton County Medical Society held their 48th Anniversary Banquet at the Piedmont Driving Club, January 9. Governor Herman Talmadge gave an address on the progress being made in hospital construction in Georgia. Dr. William G. Hamm, President, addressed the group and this was followed by the presentation of the President's Key to Dr. Jack C. Norris.

Georgia Medical Society heard Dr. John H. Ridley, associate in gynecology in the department of obstetrics and gynecology at Emory University School of Medicine, at their meeting January 13. Dr. Ridley presented a paper on endometriosis.

Randolph-Terrell Medical Society met at the Patterson Hospital, Cuthbert, January 9. An interesting

scientific program was presented by Dr. J. C. Patterson, of Cuthbert, who gave a report of several cases of amoebiasis with interesting complications including liver abscess and yellow atrophy of liver.

Richmond County Medical Society has elected Dr. W. K. Philpot president, Dr. J. H. Sherman, vice-president and Dr. Joseph L. Mulherin as secretary-treasurer.

South Georgia Medical Society held their monthly meeting at the Moody Air Force Base Hospital on January 13. After dinner, Dr. R. T. Dunn, officer in charge of roentgenology service at Moody, presented the clinical history of a case previously hospitalized at the base hospital. An open discussion followed his presentation.

Tri-County Medical Society (Bulloch-Candler-Evans) discussed and presented its plans for the coming year at their December 12 meeting. The

following officers were elected: President, Dr. John Daniel Deal; Vice-President, Dr. John Barksdale; and Secretary-Treasurer, Dr. Albert Deal. Appointed to the Board of Censors were Dr. C. E. Stapleton, Dr. J. H. Whiteside, and Dr. W. E. Simmons. Dr. Simmons was appointed Delegate to the State Convention and Dr. Curtis Hames was appointed Alternate.

Screven County Medical Society held their De-

cember meeting at the hospital and following their dinner, a round table discussion of unusual cases was featured. Announcement was made that their next meeting will be held in Waynesboro.

Ware County Medical Society, at their January 9 meeting, heard Dr. John T. Stage, anesthesiologist, Riverside Hospital, Jacksonville, who spoke on the problems of anesthesiology. Dr. Arthur Kngiht, Jr. presided at the meeting held at the Hotel Ware.

DEATHS

BRAMBLETT: *Dr. R. H. Bramblett*, 66, of Cumming, died at his residence after a long illness December 16. Born in Forsyth county, Dr. Bramblett graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta in 1911.

DOSTER: *Dr. Henry William Doster*, 86, of Augusta and formerly from Rocky Ford, died at the University Hospital in Augusta December 23. A native of Jasper County, Dr. Doster graduated from the Medical College of Georgia in 1890. For more than 50 years, Dr. Doster was actively identified with the medical welfare of the people of Screven, Bulloch and Jenkins counties.

LEE: *Dr. Lawrence Lee, Sr.* 72, of Savannah, died January 11 after an illness of several months. A

native of Charleston, S. C., Dr. Lee practiced in Savannah since 1905. He was a graduate of College of Physicians and Surgeons, Columbia University, class of 1902. Dr. Lee was a past president of the Georgia Medical Society.

LINDLEY: *Dr. F. P. Lindley*, 62, of Powder Springs, died January 1 when he was stricken with a cerebral hemorrhage. Dr. Lindley was a graduate of the Atlanta College of Physicians and Surgeons in 1912.

McGOWAN: *Dr. Hugh Strong McGowan*, 71, of Cartersville, died December 19 of a heart attack. Dr. McGowan had practiced medicine in Bartow county for the past 48 years. He graduated at the University of The South Medical College in 1904.

MOBLEY: *Dr. H. A. Mobley*, 86, of Vienna, died January 2 after an extended illness. A native of Pulaski county, Dr. Mobley was a graduate of the Southern Medical College in 1887.

PERSONALS

The Association regrets an omission in the Roster of Membership, 1952, for Bibb County Medical Society, *Thomas G. Hall*, (Life), Grand Building, Macon.

Dr. C. A. Almand, of Atlanta, has been appointed chief medical officer in the Atlanta regional office of the Veterans Administration.

Dr. Theodore J. Buaer, of Atlanta, has assumed his new duties as Medical Officer in Charge of the Communicable Disease Center, USPHS, with headquarters in Atlanta.

Dr. Hiram Bush, of Savannah, announces the opening of offices for a practice limited to allergy and diseases of the skin, at the DeRenne Apartments, Savannah.

Dr. John D. Campbell, of Atlanta, recently pub-

lished a paper in the *Journal of Nervous and Mental Disease* in which he described 18 cases of psychosis in children.

Dr. Fred J. Coleman, of Dublin, has been reappointed to the State Medical Board for a new term of four years. Dr. Coleman has been a member of the board for some time and served for the past year as president of the group.

Dr. Richard B. Éwing has opened his office for the practice of dermatology at 311 Professional Building, Macon. Dr. Éwing was graduated from the Western Reserve University School of Medicine in 1946. He served his internship at the Allegheny General Hospital, Pittsburgh, Pennsylvania, and completed his three year fellowship in dermatology at the University of Pennsylvania Hospital, Philadelphia, in November, 1950. He served in the U. S. Army from January, 1951 to November, 1952.

Dr. Irving L. Greenberg, of Atlanta, received the B'nai B'rith's fifth annual "Man of the Year" award for his outstanding service to his community.

Dr. William Holden, of Macon, left recently to visit remote sections of the Brazilian jungle in the interests of medical research.

Dr. Edward S. Marks, of Marietta, was selected by the Marietta Junior Chamber of Commerce, as Marietta's Young Man of the Year for 1952.

Dr. Malcolm T. McGoogan, of Waycross, has been certified by the American Board of Surgery.

Dr. D. Frank Mullins, Jr. has recently accepted appointment to the faculty of the Medical College of Georgia as Associate Professor of Pathology, Associate Pathologist to the University Hospital and also is a member of the Consultant Staff of the Veterans Hospital, Augusta.

Dr. J. C. Patterson, of Patterson, addressed the Cuthbert Rotary Club recently on the topic "The History of Medicine."

Dr. Carter Smith, of Atlanta, is the author of the lead article "Length of Survival After Myocardial Infarction," appearing in the January 17 issue of the *Journal of the American Medical Association*.

Dr. and Mrs. Virgil P. Sydenstricker, of Augusta,

are planning to attend the coronation of Queen Elizabeth II on June 3. However, the main reason for the trip is that Dr. Sydenstricker is scheduled to take part in a seminar to be conducted at the University of Edinburgh in May. The coronation will mix pleasure with work.

Dr. John S. Walker, of Atlanta, will be associated with *Dr. Joseph H. Patterson* and *Dr. H. Luten Teate, Jr.*, in the practice of pediatrics in their new offices at the Howell House, Suite 231-H, 710 Peachtree Street, N. E., Atlanta.

Dr. J. Calvin Weaver, of Atlanta, recently addressed the DeKalb Historical Society. His subject was the early history of the physicians in this area. Dr. Weaver has completed his work on "One Hundred Years of Medicine in DeKalb County," and his talk highlighted some of his voluminous research on medical data. Dr. Calvin has been elected President of the DeKalb Historical Society for 1953, it was announced at their January 26 meeting.

Dr. Charles W. Westerfield, of Savannah, has been appointed on the Committee on Membership of the American Society of Anesthesiologists.

HOSPITALS

Dr. Raymond F. Corpe has been appointed director of Battey State Hospital. Dr. Corpe replaces Dr. Rufus Payne who resigned as director last year to accept the position of superintendent of the new state medical hospital at Augusta. Dr. Corpe has been at Battey since July, 1952 as Chief of Surgery.

The physicians on the staff of Bulloch County Hospital entertained the nurses of the hospital, nurses in doctor's offices, laboratory technicians and the nurses staff of the health department at an elaborate dinner dance the evening of December 17.

All officers of the Cobb Memorial Hospital were re-elected recently and Dr. Seth J. Floyd was selected as new chief of staff for the hospital. Dr. Floyd succeeds Dr. W. B. Mims, Jr.

Dr. Raleigh Garner, of Gainesville, was elected chief of staff of the Hall County Hospital recently. Dr. Garner succeeds Dr. Cleve Whelchel. Dr. Ed Grove was named vice-president and Dr. Rafe Banks, Jr., was elected secretary.

Dr. Harry H. Robinson, of Charlottesville, Va., has completed negotiations for the purchase of the Haralson County Hospital. Dr. and Mrs. Robinson have moved into the hospital building and Dr. Robinson will have his office there.

Dr. Harold M. Smith, Chatham County coroner, was elected chief of staff of the Warren Candler Hospital recently. Dr. H. Y. Righton was elected

vice-president of staff and Dr. Robert Gottschalk was re-elected treasurer.

The medical staff of the new Bacon County Hospital recommended the following doctors to the consulting staff: EENT—Drs. B. F. Minchew, B. E. Collins and Leo Smith; Urology—Drs. W. F. Reavis and L. W. Pierce; Pediatrics—Dr. Harold Mueslee; Surgery—Drs. A. W. DeLoach, W. L. Pomeroy, Ansley Seaman and T. J. Ferrell; Internal Medicine—Dr. Arthur M. Knight, Jr.

At a recent meeting of the Emanuel County Hospital Medical Staff, Dr. C. E. Powell was elected chief of staff. Dr. Powell succeeds Dr. D. D. Smith, who resigned in order to operate his own private hospital.

Houston-Rentz Clinic and Merritts Hospital in Colquitt have merged into the Southwest Georgia Hospital, Inc. The new organization was formed by four Colquitt doctors; Dr. William Henry Houston, president; Dr. James W. Merritt, vice-president; Dr. Hinton J. Merritt, treasurer; and Dr. Turner W. Rentz, secretary.

Details and data from Dr. Ralph C. Williams' recent article on "One Year of Operating Experiences of 17 New Hospitals Built Under the Hospital Facilities Construction Program (Hill-Burton)" which appeared in the December issue of the *Journal of The Medical Association of Georgia*, has received statewide publicity. Material from this paper has been run in over 20 Georgia newspapers and given "play" by the Associated Press. Dr. Williams is Director, Division of Hospital Services, Georgia Department of Public Health, Atlanta.

JOURNAL of The Medical Association of Georgia

MARCH • 1953

San Francisco, 22



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The JOURNAL

of the

MEDICAL

ASSOCIATION

OF GEORGIA

MARCH, 1953

VOLUME 42 NUMBER 3



Photo by Ted F. Leigh, M.D.

Commemorating the discovery of ether as an anesthetic by Georgia's own Crawford W. Long (see Editorial), the Woman's Auxiliary has chosen the date of this event for the annual observance of Doctor's Day. While the idea of Doctor's Day originated by the Auxiliary in Georgia, it is now observed throughout the United States.

To further stimulate public interest in Doctor's Day, Fulton County Medical Society Auxiliary designed a large window poster for use in Atlanta and throughout the State. County Society Auxiliaries have distributed over 270 of the posters.

Shown placing the poster in a florist's shop window are (left to right) Mrs. Brady, of Harper's Florist, Atlanta, and co-chairman of Fulton County Auxiliary Doctor's Day Committee Mrs. Guy Adams and Mrs. Ted F. Leigh.

Next month's issue—the Annual Session number.

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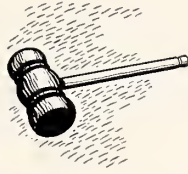
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President's Page



DR. C. F. HOLTON
MAG President

Letters From the People

(Re: article on President's Page,
November Journal)

From a North Georgia Solicitor General:

"Your statement about the present fear of the people being unable to get medical care in time of illness is a splendid and pertinent comment on the actual situation.

I am a conservative, but realize if the situation is not improved the people may do something radical in an effort to remedy matters."

He cites two cases, one patient called 14 doctors and waited five hours before he got one. Another had a heart attack at home, was unable to get a physician and was carried to a hospital where he died after waiting two hours still without having a doctor to see him.

From a prominent large City Physician:

"I consider it most timely. I have for some time been concerned over the habit of overcharges by certain members of our profession. I agree that this is a short and quick way to socialized medicine and regimentation of our profession."

From a resident of Atlanta:

"My doctor has quit practicing and recommended another. A short time ago I had an

abscess on my right arm. The doctor said he could not cut it in his office, but would have to take me to a hospital and put me to sleep. When I reached the operating room he asked me if freezing it would be all right. I told him freezing was as bad as cutting and just cut away which he did. This could have been done in his office, but I had to pay \$67.25 hospital bill which I could not afford."

From a highly respected and successful country doctor:

"I can't refrain from telling you that you hit the bull's eye and rung the bell in your article in last issue of the *Journal*. As you said we must answer all calls and not charge too much. I find that the young doctors charge too much. In some places it is almost a racket."

Someone has said that God must love the poor people because he made so many of them. The following is from one of those:

"You are correct in what you said there are 1000 and 1000 of people all over this land that can't pay such high price Dr. and medicine bills. The class of People like myself had to do little pay jobs altho somebody has got to use the tools to feed house and close the people. I started work with a RR Co for 90c a day made 40 years never missed a pay day. Lived real hard did not spend any money wasteful thin could hardly raise my children like they should be and now I am living on the little pension I get, my wife and self. No one wants a Dr to work for nothing for as I no they need to be paid right, on the other hand as I have seen the class of people that is having to live on such little incomes, they can't pay such high prices and rather than owe and can't pay lots of people will run risk of getting well without a Dr. Here where I live I used to pay a Dr \$1.50 and \$2.00 for a house call, Now the same calls they charge \$4.00 and \$6.00 for and if they give any medicine hafta get it from drug store. You see what I am trying to say and get over to you. It seems to me something ought to be done about it and I thank God for what you have already done and seen in regard to Socialized medicine. Keep the good work going peoples lives and health ought to come first and then money."

The JOURNAL of the Medical Association of Georgia

Make an adventure of all that you do
Do it with purpose and zest
Looking at life from the broad point of view
Giving your utmost and best.

Take every check as a challenge from fate
Rise above failure and fear
Face up to all things, small things and great
With a good heart and good cheer.

Make an adventure of life
Let it be thrilling, inspiring and gay
It's up to you—you can choose
You are free to make what you will of each day!

author unknown

Submitted by Mrs. Ralph Fowler
President, Woman's Auxiliary to the MAG.

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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For Information about these and other courses Address
 THE DEAN, 345 West 50th Street, New York 19, N. Y.



On The Bulletin Board

Doctor Draft Law

The Department of Defense and the Armed Services have taken steps to revise Public Law 779, the "doctor draft law." Recommended revisions incorporated in a new draft law were approved by the Armed Forces Medical Policy Council and forwarded to the Office of the Secretary of Defense for coordination with military departments. Until agreement has been reached within the Department, contents of the new bill will not be announced.

The new measure *presumably* will abolish the present categories and classify registrants into two groups: (1) All persons who did not serve in the armed forces during World War II—youngest to be called first; (2) Persons who have served—those with least amount of service to be called first. Also, the bill would provide that special registrants now classified in priorities 1 and 2 would be inducted when they became available for duty. Persons who have served on active duty for 12 months or more subsequent to June 25, 1950, would not be liable for further military service.

Other AMA recommendations which have been acted upon by the Armed Forces Medical Policy Council:

(1) Thorough study of dependent medical care—although a study is warranted, AFMPC reports that further action must be taken by the new Secretary of Defense.

(2) Study of percentage of physician's time spent in treating other than military personnel—study currently is under way.

(3) Revision of physical requirements for physicians being examined for military service—the Department of Defense adopted a new policy which will consider all physicians potentially acceptable for military service provided they can be reasonably productive in the armed forces. Military departments have been directed to re-evaluate physicians previously disqualified. Approximately 2,600 physicians in priorities 1 and 2 will be re-examined.

Selective Service Data

The following named Special Registrants of Georgia local boards will be issued orders to report for induction by Selective Service System for March 31, 1953, in accordance with Special Call No. 12:

PRIORITY III—PHYSICIANS •

Smallwood, Henry Clayton, 3823 Cleveland Ave., New Orleans, La.

Farris, John D., Box 63, Emory University, Ga.

Smith, William, Rt. 12, Knoxville, Tenn. (Commissioned)

Schwartz, Larry A., Charity Hospital, New Orleans, La.

Andrews, Samuel Edward, 1405 N. 33rd St., Birmingham, Ala.

Glover, Adis G., Box 350, Canton, Ga. (Commissioned)

The following doctors recently released from military service and now in training would like further training or practice in Georgia.

Dr. George J. Fruthaler, Jr., 2120 Pine St., New Orleans, La. Will complete training at Ochsner Clinic Dec. 31, 1953, and desires pediatric practice.

Dr. James H. Brown, R.F.D. 1, Rossville, Ga. Now in Neurological Residency at Georgetown Univ. Hospital, Washington, D. C. Private practice in Neurology and Psychiatry.

Dr. Vincent F. Cordaro, 2751 Barnes Ave., New York 67, N. Y. Anesthesiology.

Dr. Louis Alton Munro, 1301 Rigdon Rd., Columbus, Ga. Ophthalmology Residency.

Dr. Denman Hammond, Children's Hospital, Philadelphia 46, Pa. Residency training in Pediatrics at second year level for July, 1953.

Dr. William S. Lyles, 1917 Seneca Ave., Columbus, S. C. Now in final year residency in General Surgery. Desires practice in Georgia in general surgery.

Locations Seeking Physicians

Need expressed for a colored doctor for Marietta and Cobb County. Colored population of Cobb County, 6224; of Marietta, 2980. (Contact Dr. E. A. Musarra, Cobb County Medical Society, Marietta, Ga. for information.)

Trenton, Georgia, county seat of Dade County, is a good location for one or two good young doctors willing to work, able to do internal medicine and a little surgery. A small 10-15 bed hospital would be very useful and profitable to the doctors, town and community.

Rising Fawn, Georgia, also needs a good doctor. It is a hustling town with only one doctor who is over 80 years old. Trenton and Rising Fawn are both located on Chattanooga-Birmingham highway.

Chicamauga, Georgia, could also use another young doctor.

(For information concerning these 3 locations, contact Dr. H. F. Shields, Walker-Catoosa-Dade Medical Society, Chicamauga, Ga.)

One Hundred Third Annual Session
MEDICAL ASSOCIATION OF GEORGIA
Savannah, Ga., May 10-13
Featuring PANEL DISCUSSIONS on . . .

Treatment of Burns . . .

MODERATOR: Everett I. Evans, M.D., Richmond, Va., Professor of Surgery,
Medical College of Virginia (tentative)

PANEL: S. A. Roddenberry, M.D., Columbus; George Tootle, Atlanta.

Your State Vocational Rehabilitation Program . . .

MODERATOR: C. C. Aven, M.D., Atlanta

PANEL: Tom Goodwyn, M.D., Atlanta; Julius Quattlebaum, M.D.,
Savannah; Lester Harbin, M.D., Rome; M. B. Hatcher,
M.D., Macon; Braswell Collins, M.D., Waycross; Mr. A. P.
Jarrell, Div. of Vocational Rehabilitation, Atlanta.

Insurance Problems in Georgia . . .

MODERATOR: Mr. H. B. Coolidge, Executive Director, Physicians Service
Association, Savannah.

PANEL: W. S. Dorough, M.D., Atlanta; W. L. Pomeroy, M.D., Way-
cross; John Elliott, M.D., Savannah; J. Z. McDaniel, M.D.,
Albany.

Special Symposiums On . . .

- | | |
|----------------------|---|
| (1) Gastroenterology | (3) Orthopedic Surgery (emphasis on Trauma) |
| (2) Vascular Surgery | (4) General Practice |

The Following Sections Will Meet . . .

- | | |
|-----------------------|-------------------------------|
| (1) Internal Medicine | (5) Industrial Surgery |
| (2) General Practice | (6) Pathology |
| (3) Surgery | (7) Obstetrics and Gynecology |
| (4) Pediatrics | (8) Thoracic Diseases |
| | (9) Radiology |

The Following Specialty Societies Will Meet . . .

- (1) Georgia Radiological Society
- (2) Georgia Pediatric Society
- (3) Georgia Urological Society (Luncheon)
- (4) Georgia Society of Ophthalmology and Otolaryngology (Luncheon)
- (5) Georgia Industrial Surgeons Association
- (6) Georgia Society of Anesthesiologists (Luncheon)
- (7) Georgia Association of Pathologists
- (8) Georgia Society of Neurology and Psychiatry
- (9) Georgia Academy of General Practice
- (10) Georgia Chapter, American College of Surgeons
- (11) Georgia Chapter, American College of Chest Physicians
- (12) Georgia State Obstetrical and Gynecological Society
- (13) Georgia Trudeau Society (Luncheon)
- (14) Georgia Orthopedic Society (Luncheon)
- (15) Medical College of Georgia Alumni Association (Dinner)
- (16) Emory University School of Medicine Alumni Association (Dinner)



A. M. E. F. Page

The following physicians, listed by county medical society, have contributed to the AMERICAN MEDICAL EDUCATION FOUNDATION in February, 1953. Those making their contribution direct to the AMEF Headquarters may not be listed unless official notification has been received therefrom.

FULTON COUNTY MEDICAL SOCIETY

Poer, David Henry, Atlanta

Rogers, J. Harry; Atlanta

FLOYD COUNTY MEDICAL SOCIETY

Harbin, Jr., William P.; Rome

JACKSON-BARROW COUNTY MEDICAL SOCIETY

Randolph, W. Quenton; Winder

WILKES COUNTY MEDICAL SOCIETY

Duggan, Asa Daniel; Washington

Medical Schools in Financial Need

American medical schools need an average of \$250,000.00 more each year in order to do a really first-rate job, according to the president of the Association of American Medical Colleges.

Chief cause of the financial crisis, according to Dr. Darley, AAMC president, is the 500 per cent increase in operating costs of the medical schools over the past 30 years. Aside from the increased costs of educating medical students, the medical schools also are called upon to help in the instruction of many kinds of health personnel other than future doctors, furnish medical services to the community, and support extensive research activities in order to keep pace with the constantly advancing field of medical science.

Our changing economy also has a part in contributing to the difficulties of the schools, Dr. Darley says. Although in 1941 35 per cent of the schools' income came from endowment interest, this percentage dropped to 20 per cent in 1948 despite a 21 per cent increase in endowment capital.

While not recommending any single course of action, Dr. Darley summarizes the various ways in which medical schools can brighten their financial picture. These include selling medical and hospital services, increasing community support for operation of teaching hospitals and clinics, recovering the actual costs involved in research programs, receiving larger city and state appropriations, soliciting more and larger gifts, grants and endowments, increasing tuition and, perhaps, accepting federal subsidy.

Dr. Darley noted that in reference to increasing tuition, charges are now an average \$623 annually, an increase of 165 per cent since 1939. Increases in tuition will further overburden the financial resources of most students.

THE JOURNAL OF MEDICAL EDUCATION

Moribund Schools

To borrow a medical term, the state of U. S. medical schools is practically moribund.

Ten million dollars additional annual income is needed just to meet current operating deficits, let alone demands for more doctors. The schools have all been forced to retrench at the expense of teaching standards. One in 20 full-time teaching positions is vacant. Faculty time per student is seven per cent lower than a year ago.

Between 6,500 and 7,000 students are graduated annually, and although this is a thousand more than 10 years ago, it is still not enough to help relieve the shortage of doctors.

It goes without saying that lowering of our medical training standards would be a national disaster. The American people have become used to having highly skilled physicians, research scientists and public health specialists to look after their health, happiness and welfare. Medical advances benefit society only if there are a large number of competent doctors to apply them.

Yet, unless private support is withcoming for medical schools, according to the National Fund for Medical Education, they have no choice but to lower their standards, close down entirely or accept federal aid in large amounts.

Private support for medical schools would be preferable to government subsidization, of course, in order to keep one more load off the taxpayer's back, but the medical profession might as well prepare for federal aid to such schools if private support is not forthcoming, for the nation will not permit deterioration of its medical school standards.

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The Bookshelf

BOOKS RECEIVED

TREATMENT OF MENTAL DISORDERS By Leo Alexander, M.D., Director, the Neurobiological Unit, Division of Psychiatric Research, Boston State Hospital, and Instructor in Psychiatry, Tufts Medical School. 507 pages with 143 figures. Philadelphia and London: W. B. Saunders Company, 1953. Price \$10.00.

THE ANATOMY OF THE NERVOUS SYSTEM, Its Development and Function: By Stephen Walter Ranson, M.D., Ph.D., late Professor of Neurology and Director of Neurological Institute, Northwestern University Medical School, Chicago. Revised by Sam Lillard Clark, M.D., Ph.D., Professor of Anatomy, The Vanderbilt University School of Medicine, Nashville. New, 9th Edition. 581 pages with 434 illustrations, 18 in color. Philadelphia and London: W. B. Saunders Company, 1953. Price \$8.50.

AMERICAN POCKET MEDICAL DICTIONARYS A Dictionary of the Principal Terms Used in Medicine, Nursing, Pharmacy, Dentistry, Veterinary Science, and Allied Biological Subjects. New, 19th Edition.

639 pages. Philadelphia and London: W. B. Saunders Company, 1953. Price \$3.25 Plain; \$3.75 with Thumb-Index.

A MANUAL OF CLINICAL ALLERGYS By John M. Sheldon, M.D., Professor of Internal Medicine, University of Michigan Medical School; Robert G. Lovell, M.D., Instructor in Internal Medicine, University of Michigan Medical School; Kenneth P. Mathews, M.D., Assistant Professor of Internal Medicine, University of Michigan Medical School. 413 pages with 27 figures. Philadelphia and London: W. B. Saunders Company, 1953. Price \$8.50.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY: By Francis Heed Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School. Consulting Surgeon, Wills Eye Hospital, Philadelphia. New, 5th Edition. 488 pages with 281 figures and 26 color plates. Philadelphia and London: W. B. Saunders Company, 1953. Price \$7.50.

HOSPITAL STAFF APPOINTMENTS OF PHYSICIANS IN NEW YORK CITY: By Hospital Council of Greater New York. 151 pages and 58 tables. New York, 1951, The MacMillan Company. Price \$3.25.

REVIEWS

AMERICAN POCKET MEDICAL DICTIONARY, New 19th Edition, W. B. Saunders Company, 1953, Price (Plain) \$3.25, (With Thumb-Index) \$3.75.

This is the nineteenth edition of a dictionary containing the principal terms used in medicine, nursing, pharmacy, dentistry, veterinary science and allied biological subjects. Obsolete terms have been eliminated and new terms have been added. An earnest effort has apparently been made to define words in a simple and brief manner. It is a good, small, dictionary that should meet the daily needs of most persons interested in the medical sciences.

THE LITERATURE ON STREPTOMYCIN, By Selman A. Waksman, Rutgers University Press, \$5.00.

This book contains 5,550 references of articles published on streptomycin between the years 1944 and 1952. It is, therefore, a reference manual for investigators of antibiotics. There are two indices provided. The first index contains a list of authors who have contributed to the streptomycin literature and the second index deals with the various diseases for which streptomycin has been used. The latter index, the subject index, would allow one to quickly obtain a list of references dealing with certain aspects of streptomycin and its use in various diseases.

This book adequately fulfills the purpose for which it was written, namely: to list all available references regarding streptomycin. The very nature of such an endeavor limits the usefulness of the book to those having access to a very large medical library. It, therefore, will be of no value for the practicing physician but should be retained on the library shelf so that one has ready access to all references dealing with streptomycin.

THE MEDICAL CLINICS OF NORTH AMERICA, January Issue, W. B. Saunders Company, \$18.00 (Yearly Subscription).

The January issue (symposium from Chicago) of the Medical Clinics of North America deals exclusively with gastro-intestinal diseases. The material presented has practical clinical value for the general practitioner of medicine and covers many common problems. Dr. Walter C. Alvarez reports on "Functional Diseases of the Stomach and Colon." He comments on belching, heartburn, flatulence, constipation, etc. While his explanation for the production of such symptoms are quite superficial, usually fortified by "a" case, the general theme is good. The reviewer objects to the statement made regarding spastic colitis that "The essential point is always to get the woman (it is usually a woman) to see that she inherited from a nervous mother or relative, a tendency to get mucous colics." The passages on

carcinoma of the stomach, cirrhosis of the liver, acute and chronic hepatitis and diseases of the spleen are well written important articles. The chapter on office proctology is especially good.

STANDARD VALUES IN BLOOD, Edited by Errett C. Albritton, W. B. Saunders Company, 1952, 199 pages.

During the present century, and particularly in the past 25 years, a tremendous quantity of data has accumulated through research on blood. Two organizations, the American Institute of Biological Sciences and the National Research Council, have cooperated through their Committee on the Handbook of Biological Data, in compiling most of the facts that can be measured on normal blood. The work involved in assembling and assessing the material is almost inconceivable. So many articles had to be reviewed that one fourth of the book is in the form of bibliography, and literally thousands of references are included.

In the words of the editor, "The tables in this unusually complete collection of data on blood are unique in the high degree of reliability sought for the data. Data have been supplied and authenticated by over 600 leading investigators in biology and clinical medicine. The tables have been exhaustively reviewed, some by as many as 20 experts in the field." The material is presented altogether in tabular form, and includes facts not only about human blood but about the blood of many vertebrates.

The contents include the following subjects: physical properties; coagulation phenomena; blood groups; erythrocytes and hemoglobin; leukocytes; blood and bone marrow cells; water, carbohydrates, liquid, protein; amino acids, non-protein nitrogen; phosphorus,

sulfur; vitamins, hormones, enzymes; electrolytes, minerals, gases, acid-base; effects of radiation, storage; and therapeutic agents.

Assuming that the data presented are as accurate as they can be today, this book will prove invaluable as a reference volume. In a field where so much research is constantly going on, it is anticipated that frequent laborious revisions of this book will be required. This book will prove a "must" for all people concerned with research and teaching in the field of hematology. The ordinary practitioner of medicine will not find so much use for it. We should feel grateful for the farsightedness of those who have conceived and provided it, for it is a milestone in our scientific progress.

HOSPITAL STAFF APPOINTMENTS OF PHYSICIANS IN NEW YORK CITY, Hospital Council of Greater New York, New York, The MacMillan Company, 1951. Price \$3.25.

This report deals with a two year study of a Committee appointed by the Hospital Council of Greater New York. At the beginning of the Committee's study the following questions were posed:

1. What should be the responsibility of hospitals to the physicians in a community?
2. What should be the proper proportion of physicians having staff appointments?
3. How many physicians should be on staffs of individual hospitals?
4. How many physicians should have privileges for admission of private and semi-private patients?

It is the authors' hope that their studies answered the questions. Hospital superintendents and physicians interested in this aspect of medical problems will find the book useful.

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In the Editor's Mail

To the Editor:

Thanks for your very nice letter regarding our Journal.

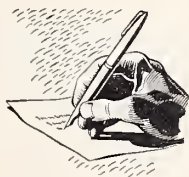
We have been impressed with the new look in your *Journal* which has been very well considered by some of our Publication Committee, as an example of Progressive Journalism especially your handling of scientific papers.

Very sincerely,
Wilfrid Haughey, M.D., Editor Jrl.
Michigan State Medical Society

Secretary-Treasurer
Medical Association of Georgia

The "Certificate of Appreciation" arrived and brought with a pleasant surprise.

Thank you so much,
Sincerely yours,
J. A. Redfearn, M.D.



To the Editor:

The improvements in your *Journal* are excellent. We like the cover, the format and other devices you have used to brighten it up.

Congratulations.

Sincerely,
J. P. Sanford
Associate Editor
Journal of the K.S.M.A.

Secretary-Treasurer
Medical Association of Georgia

This morning I received the Certificate of Appreciation from the Medical Association of Georgia and this note is to let you know of my sincere appreciation.

Thanking you for your kindness and assuring you of my full cooperation at all times, I remain

Fraternally yours,
Allen H. Bunce, M.D.

About Our Contributors

JAMES E. ANTHONY, JR., M.D., now serving as Captain with the 176th Medical Detachment in the Republic of Korea, and JOHN K. DAVIDSON, III, M.D., of Columbus, collaborated on the article "Relapsing Febrile Nodular Non-Suppurative Panniculitis (Weber-Christian's Disease), Report of a Case with Autopsy Findings." Dr. Anthony is a graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, 1947, and was recently attached to the U. S. Army Hospital, Ft. McPherson, Ga. Dr. Davidson is a graduate of Emory University School of Medicine, 1945.

CHARLES S. JONES, M.D., of Atlanta, author of the article on "Further Efforts to Reduce Mortality in Peptic Ulcer Hemorrhage" is a graduate of Cornell University Medical College, 1941.

H. E. NIEBURGS, M.D., Augusta, contributed the work "Controversies, Facts and Detection of Pre-invasive Carcinoma of the Cervix Uteri." Dr. Nieburgs is a member of the faculty at the Medical College of Georgia.

GUY V. RICE, M.D., of Atlanta, who wrote the article "National Conference on Aging," is the Director of the Health Conservation Services, Georgia Department of Public Health. He is a

graduate of Baylor University College of Medicine, 1928.

ROBERT F. SCHARF, Ph.D., of Atlanta, author of the article "Can You Retire, Doctor?" is a member of the faculty of the Social Science Department, Georgia Institute of Technology.

H. F. SHARPLEY, JR., M.D., of Savannah, is the author of the article "General Aspects of Maternal Care in Georgia." Dr. Sharpley is a graduate of University of Pennsylvania School of Medicine, 1926.

STEWART SMITH, M.D., of Chattanooga, Tenn., and M. HINES ROBERTS, M.D., of Atlanta, collaborated on the article "Congenital Adrenocortical Insufficiency." Dr. Smith is a graduate of Vanderbilt University School of Medicine, 1942, and Dr. Roberts is a graduate of Medical College of Georgia, 1918.

SAM M. TALMADGE, M.D., of Athens and D. F. MULLINS, JR., M.D., of Augusta, are co-authors of the article "A Practical Consideration of Thromboembolism." Dr. Talmadge graduated from Harvard Medical School, 1935. Dr. Mullins, Jr., is a graduate of Emory University School of Medicine, 1942. He is a member of the faculty of the Medical College of Georgia.

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DOCTOR'S DAY *Marks the* ANNIVERSARY *of the Discovery of* ANESTHESIA

No event in the history of medicine has added more to human health and longevity than the discovery of surgical anesthesia, which accounts in part for the controversy which has existed as to whom belongs the honor of being the real discoverer. In spite of the fact that the story has been published repeatedly over a long period of time showing Crawford W. Long to be the discoverer, various radio and television programs, advertisements and newspaper and magazine articles continue to proclaim the Boston dentist, William T. G. Morton, as the discoverer. Undisputed records show that Long used ether successfully as an anesthetic agent in a surgical operation four and one half years before Morton used it (Jefferson, Georgia, March 30, 1842), and also performed six other such operations before Morton gave his first demonstration (Boston, October 16, 1846).

It is claimed that while Long may have been the first to use anesthesia, he did not give it to the world, which is a distinction that should belong to Morton. Long's first operation was done in his office before a small audience of prospective medical students, while Morton's took place at the Massachusetts General Hospital in the presence of a group of prominent Boston surgeons. But careful consideration of the facts shows that Morton did not *give* the great discovery to the world, but that it had to be *taken* from him. So desirous was he and his partner, Charles T. Jackson, to accumulate a fortune from the discovery that they attempted to conceal the identity of the ether and keep it as a secret substance to be used by others only after paying the conspirators a price. In this plot they were foiled by the operating surgeons who forced them to reveal the true nature of the anesthetic substance before they could administer it again in their hospital. On the other hand, Dr. Long, always ethical and dignified, made no secret of his discovery, but broadcasted its full details by every means at his command.

It is believed by many unprejudiced minds that Morton learned of the possibility and practicability



Crawford W. Long, M.D., 1815-1878

of ether anesthesia from Crawford Long through the Boston physician, chemist and geologist, Dr. Jackson. Morton admitted that the idea came to him from Jackson, and it is well-known that Jackson was interested in the gold mines at Dahlonega, Georgia, and made at least two visits to this part of the state at about the time of Long's discovery. Many substantiated facts have been given showing how Dr. Jackson could have obtained the valuable information concerning Long's achievement and carry it to Boston.

Georgia is proud of her native son, Crawford Long, and no tribute to him is too great for his incomparable gift to humanity. It is most appropriate for the Woman's Auxiliary of the Medical Association of Georgia and the nation to observe March 30th with its attractive program as "Doctor's Day."

FRANK K. BOLAND, SR., M.D.

EDGAR DEWITT SHANKS, SR., M.D.

An Appreciation

Doctor Edgar D. Shanks, Sr., was born November 21, 1889 at Banks, Alabama, a member of a large family, consisting of himself and four sisters and two brothers. He was the son of Mr. and Mrs. Z. W. Shanks, who were well known in their locality as hard-working, Godfearing Baptists. After primary schooling Ed, as he was called, left the homestead and faced the world on his own. Early in life he became fascinated by telegraphy and in a very short time became a skillful operator, which enabled him to easily secure a job wherever he sought one. During those younger years he traveled extensively from coast to coast and into almost every state of the Union. Eventually, he tired of roaming around and decided that he would study medicine and entered the Atlanta College of Physicians, now Emory University Medical School, and graduated with honors in the famous class of 1913. He was one of the first graduates to take a routine internship at Grady Hospital; he also attended Telfair Hospital in Savannah and the Post-Graduate Hospital in New York. Later on he became a member of the medical department of Emory University and taught internal medicine at Grady for years.

When the United States entered World War I, Doctor Shanks joined the army and was first sta-



Edgar DeWitt Shanks, Sr., M.D.

tioned at Camp Gordon. Overseas, he served in France and Germany, in the 82nd Division. Upon leaving the war zones, where he had the misfortune to become ill, he returned home to recover, later going into practice here in Atlanta.

During World War II he became an active member of the State Procurement and Assignment Committee for Physicians, holding this important place from 1942 to 1945, and was cited for excellent work. During World War I, or prior thereto, Doctor Ed had the good fortune to meet the lady who became his wife, Miss Zola Thomas of Virginia, a distinguished lady from a splendid family. She was one of the first nurses to specialize in anesthesia in Georgia, and one of the most lovable and devoted women I have ever known. Three children were born of that union: Edgar, Junior, Zola, and Jimmie.

Doctor Shanks became a member of many different societies, of local and national importance, including the American Medical Association and the Medical Association of Georgia, and the Phi Chi Medical Fraternity. As president of the Fulton County Medical Society, 1935-36, he was instrumental in helping to make progressive moves for that organization, including the sale and purchase of property and raising funds coincident to building our new Academy of Medicine. Doctor Shanks was also secretary of the Medical Association of Georgia, and Editor of the *Journal* for 16 years, serving in that dual capacity longer than any other physician. During this period he was active on all of the important committees concerned with the advancement of medicine in Georgia, guiding and building our Association to a high place in the nation, with a membership in 1950 of more than

2,279 doctors, thus adding to its capital and establishing for the Association a reputation as a leading state organization. As the editor of the *Journal* it was necessary for him to do a considerable amount of writing and editing on local, state and national levels. His contributions were distinguished by brevity and a lucid style. Indeed, as an Editor, he ranked among the best in the United States. It would seem unnecessary to add that as a physician he was among our leaders, blessed with an excellent memory, with sound basic viewpoints in medicine, being a skillful diagnostician, trusted both by his patients and his professional confreres.

With those thoughts behind me, I also wish to write a few impressions of my friend, in retrospect. I first met Doctor Shanks shortly after my arrival in Atlanta in 1928, and as I recall it, was introduced to him by Doctor Adams, then professor of pathology at Emory, in whose department I was working and studying. Doctor Adams was living at the Shanks home. From the beginning of our acquaintance, Doctor Ed and I were friends. He invited me to visit and dine in his home. I was impressed by his Christian home life and came to have great admiration for Mrs. Shanks, also. We were interested in many mutual things, such as hunting doves, writing, reading history and philosophy, politics, and medicine. We also traveled much together during the following years and spent hours exploring our thoughts and problems, making plans for the future; all of which added materially to my development as a young physician; thus it was that I came to know Dr. Edgar D. Shanks well; very well, indeed.

Doctor Shanks, as his minister said at the funeral, "was a man who retained many of the older virtues and values of life." That is absolutely true; a firm believer in the good home and in strong parental authority, he expected the best of his children, his friends, and his family, and to them he gave his best in return. Having come up the hard road of life, he considered every one's self-respect, dignity and reliability, just as he did his own. He had known what it was to be hungry and he feared becoming dependent upon his friends for anything. Thus, he had a high record for frugality. He learned to invest soundly and to save some part of his yearly income, and believed that if a person could not save he should not be entrusted with money and that those people who would not put something away for a rainy day had little hope of ever having much in the way of worldly goods. Therefore, he cared for other people's money which he administered as though it were his very own. One of his proudest accomplishments was the reserve fund he established for the Medical Association of Georgia. We can correctly state that Shanks was a "rugged individualist."

In his practice of medicine he had solid principles. While tolerant of a doctor's honest mistakes, he never condoned "sorry" practice and unethical conduct and was a fervent enemy of quackery. Neither was he a cheap doctor. Having served a patient to the best of his ability, he felt that he should be paid in accordance with established traditions and for his

worth. With his close friends he was intensely loyal and, when necessary, was always willing to go to bat for them if he felt that they had been maligned or mistreated. That feature of his character stood out and it might well be said that, if necessary, he would "wade in where angels feared to tread." In defense he was effective and brave. Whenever he felt that he personally had been wronged, one would soon feel the lash of his tongue and the sting of his reproach. He had his own opinion of charity, of which he did much. People in his community would be astounded if they but knew the large number of young men he had helped to get into medical schools and other colleges in order that they might complete their educations, not only arranging for financial help for them but gave them rooms in his home and guidance through their struggles. Everyone who knew him, was well aware that, while he maintained a dignified front, he had a keen and enthusiastic humor, was an excellent story-teller and whenever in conversation, those about him seemed to appreciate listening to him.

I cannot forget how deep was his devotion to his dear old father. Often, after a long day's work at the office, he would see to it at home that the old gentleman, who was unable to care for himself, had a hot bath and would then proceed to shave him! Later on, when Mrs. Shanks was stricken with a fatal illness, Doctor Ed insisted that he would take the "night-watch" alone, as it were, by her bed-side through the dead hours, night after night, administering to her needs. That he did faithfully until her death. Only Doctor Shanks' closest associates knew that he was deeply sentimental and was easily hurt. But he felt that a show of sentiment was a sign of weakness and many times I have watched him force back tears that should have poured down his cheeks. When a few of his colleagues met at his bed-side not long ago, on a Sunday afternoon and there presented him with a set of silver in recognition of his service to Georgia medicine, his personal reaction and appreciation was boundless and warm. He had little to say on that occasion but all present knew the depths of his feeling. When he made the decision to again offer for election to continue as secretary of the Medical Association, many of his advisors felt that it would be a mistake for him to do so; yet, knowing also how he felt about it, they could do nothing but rally to his plan and fight the battle out. He firmly and sincerely thought he deserved another term, but was grateful for the support given him, with no animosity toward those who did not vote for him.

Doctor Shanks, it has been said, "knew more doctors than did any other man in Georgia. I would also add that he not only knew them, but more about them, both good, bad, and indifferent, than did any other Georgia Doctor. With that vast store of information, he became a constant source of inquiry; nevertheless he carefully guarded any man's reputation to the nth degree. Thus he made friends, acquaintances and a few enemies. On the other hand, he had only a very few close personal friends. He

always said that J. C. Patterson was the best all-round physician and surgeon in the state; that C. F. Holton was a clever person and a good doctor; his admiration for Spencer Kirkland was deep-rooted and intense. Many a time he told me about happy days he had spent with those gentlemen, and that Kirkland was the "most completely unselfish man he had ever known." C. Mulkey West and his son Edward were two who enjoyed his confidence and devotion.

Doctor Shanks was not much given to church work, but was very tolerant of religious beliefs and a strong believer in Presbyterianism. As to his personal faith, just what he believed about the hereafter I am not sure that I know; yet, I think I know. Doctor Shanks loved life and living and, as I have inferred, was always interested in almost everything going on around him, including national politics, being an out-and-out Jeffersonian democrat of the old school. As a Mason, he had been inactive in recent years.

Until the afternoon prior to his death, his mind was clear as a bell and orderly in its thinking. His illness, never-the-less, was an ordeal and a terrible misfortune; being a physician made things worse, for he admitted that his remaining days were few and numbered. His stoicism in the face of his outlook was almost beyond human understanding. The last few years of his life had been fraught with sorrow

and, following Mrs. Shanks' death, he was sorely alone and miserable, and felt the burdens of his responsibility without her; yet, God had blessed him with strong sons, and a devoted daughter who stood by his side closely and staunchly. Sad as his burdens were, however, it appeared to me that, after a period of time, he did seem to take on new interests and made an effort to start over in living, only to later—and soon thereafter—find out that at 61 years of age, Death was tweaking his ear; thus, his heart broke. Yet he suffered boldly, and asked no quarter or charity of anyone. He died at his home, asleep, in the early morning, February 12, 1953.

Whenever one writes about a departed friend, one should not write lightly, for his pen is dipped in the ink of historic responsibility. It is correct, then, to record in summary that Doctor Edgar D. Shanks, like all of us mortals, had his few indifferent points, as well as many good ones. Now that he lies dead, as we all shall some day lie, we must keep burning before us those good examples of his which he bequeathed to us, and write his faults in the silvery snow of yonder foot-hills, where the warmth of the sunshine shall melt them away. Personally, I shall not soon forget him; indeed, I shall never know another man like him. Georgia has lost its best known doctor; Atlanta, a spirited citizen, and the medical profession a true friend.

CHOLESTEROL

and

ATHEROSCLEROSIS

With life expectancy among the general population becoming lengthened each year, the problem of morbidity and mortality secondary to atherosclerosis becomes increasingly important. As recently as two decades ago, the concept prevailed that arteriosclerosis was an inevitable phase in the process of aging. For many years this concept played an important role in the limitation of research in the field.

While all forms of arteriosclerosis are generally considered manifestations of the same pathophysiologic process, atherosclerosis is from the clinical standpoint, by far the most important variety. Man

is unique among the mammals in his predisposition to atherosclerosis. Western man, especially in those situations where the level of nutrition is high, seems particularly susceptible. Among orientals, on the other hand where the dietary is generally deficient, the incidence of this destructive process is significantly low. The lesion does not occur to any significant extent in the ordinary laboratory or domestic animals. Anitschkow was able to demonstrate experimental atherosclerosis some 40 years ago by cholesterol feeding in rabbits. Only in the past decade have the chicken and dog been used in its experimental production. In producing the initial gross

lesion in these experimental animals, a sustained hypercholesterolemia and hyperlipemia appear to be common denominators. These are enhanced by increased amounts of cholesterol and fat in the diet. Recently, Bragdon has reported that suckling rabbits universally develop focal deposits of sudanophilic material in the aortic intima. This occurs in the presence of elevated plasma lipid levels. During the weeks of rapid growth that immediately follow weaning, the lipid deposits usually disappear completely. In the sexually mature rabbit of either sex, new microscopic deposits may reappear presumably at time. As these spontaneous lesions are identical in distribution and in histologic appearance with those produced in the first weeks of experimental cholesterol feeding, they are interpreted as representing early reversible lesions of rabbit atherosclerosis. Correlation with plasma lipid levels in the mature animal is less conclusive. Experimental pancreatic diabetes, experimental hypothyroidism, and liver damage by carbon tetrachloride have each been shown to enhance experimental atherosclerosis. Clinically, it is well established that hypothyroid and diabetic individuals manifest an increased susceptibility to atherosclerosis. Prolonged biliary obstruction, nephrosis, familial hypercholesterolemia and xanthomatosis with their associated high serum cholesterol levels all show an increased vulnerability to atherosclerosis. There is no good evidence that the liver damage per se, in clinical cirrhosis predisposes to atherosclerotic change. The administration of ACTH, DOCA, or Cortisone have each been shown to increase the severity of experimental atherosclerosis. Plasma cholesterol levels are uniformly elevated in Cushing's syndrome and following prolonged administration of adrenal steroids.

The greater incidence of coronary artery sclerosis in the male has recently been investigated by Dock. He finds that the intima of the coronary arteries is considerably thicker in the male at birth and continues so throughout life in most instances. This, rather than any fundamental metabolic difference, would appear to explain its increased incidence in the male. Hypertension is also known to increase the severity of the lesion. More than 50 per cent of hypertensives manifest significant sclerotic changes. Local injury to the vessel wall also predisposes to atheroma formation.

Within the past year Rhinehart has reported atherosclerotic lesions to develop regularly in the rhesus monkey subjected to prolonged pyridoxin deficiency. While the histological analogy is substantial, it does not follow that pyridoxin deficiency is necessarily concerned in the genesis of the human disease. Lipid changes in the lesions were not apparent in the early stages. For this reason Rhinehart has postulated that the accumulation of lipids is a secondary development in the evolution of atherosclerosis.

Interest in the entire problem of atherosclerosis was stimulated two years ago by the reports of Gofman and his associates at the University of California. Their studies with the ultracentrifuge

have revealed significant relationship between plasma levels of abnormally large lipoprotein molecules and atherosclerosis. This group has shown that the serum level of these large molecules (Sf10-20 fraction) can be reduced by feeding an extremely low cholesterol diet and suggest such a diet in treatment. Their theories, while attractive, have not yet been fully confirmed in other laboratories.

Keys at the University of Minnesota has recently taken strong issue with Gofman's claims. By statistical analysis of Gofman's data, he has shown a substantial correlation between total human serum cholesterol levels and the concentration of giant lipoprotein molecules. Both substances show distinct tendencies to be maintained in higher concentration in the serum of persons with coronary disease than in clinically healthy persons. Neither measurement however, is a dependable means of discrimination between such patients and healthy persons. Keys feels that if there is any advantage to one of these measurements over the other, the evidence is in favor of total cholesterol.

Within the past fortnight Rhinehart, also at the University of California, has taken new issue with the findings of Gofman, this time via a national weekly lay publication. He reiterates his belief that lipid deposits are a secondary manifestation in the natural history of human atherosclerosis. Thus the "great debate" continues. Whatever its final outcome, the work of Gofman and his associates must be credited with the stimulation of an unprecedented interest in this heretofore neglected field.

In the light of the foregoing evidence, there seems little doubt that an altered cholesterol and lipid metabolism are important factors in the production of both experimental and clinical atherosclerosis. However, the exact mechanism is still unproved, and the efficacy of long term dietary measures remain uncertain.

The evaluation of therapy in clinical atherosclerosis presents many difficulties. The experimentally produced lesion remains our only means of a quantitative approach to the problem of treatment.

There is evidence that the lesions of experimental cholesterol atherosclerosis show marked regression and even complete healing within a few weeks after cholesterol feeding is discontinued. Undernutrition, has been shown to decrease the severity of experimental lesions. Extensive and well controlled studies carried out in Norway and other occupied countries during the late war revealed the incidence of arteriosclerotic heart disease and generalized arteriosclerosis to be much diminished during prolonged periods of dietary privation. Following the resumption of normal diet, the incidence returned to its previous levels. On the basis of these findings it is difficult to explain how in the Eskimo, whose diet is extremely high in fats, there is no increased susceptibility to atherosclerosis. The so called lipotropic substances, choline, inositol and methionine have no significant effect in altering the course of experimental lesions.

Intravenous heparin has been found to influence alimentary lipemia by effecting rapid clearing of plasma lactescence through disruption of lipid-protein bonds. Repeated heparin injections effectively decrease experimental cholesterol atherosclerosis. Clinical trials with heparin have shown similar clearing of plasma lactescence soon after its I. V. administration. Ultracentrifuge studies reveal a shift of serum lipoproteins from the larger so called atherogenic classes to the smaller non-atherogenic group. Some workers have reported improvement in angina or ballistocardiographic pattern within six hours after heparin administration. These investigators presume that heparin may lyse deposits of large lipoprotein particles adhering to the vessel intima.

Intravenous injection of such detergents as Triton A-20 decrease the cholesterol phospholipid ratio while increasing the plasma phospholipids in experimental cholesterol atherosclerosis. This results in an inhibition of the lesions. The exact role of potassium iodide in its inhibition of experimental atheromata remains on tenuous ground, as does its usefulness in the clinical situation.

Thus we may conclude that atherosclerosis is a disease and not an inevitable consequence of aging. It is a reversible process. Preliminary investigations would seem to implicate an alteration of lipid metabolism in most instances. We have seen that these alterations may be congenital or acquired in a variety of ways. Much of our accumulated evidence is fragmentary and apparently conflicting. May we not then consider the entire process as a host response to injury or stress, whether it be mechanical as in the case of local injury to a vessel wall, or

response to a sustained hypertension, or more subtle as in a situation of prolonged psychic stress and secondary hypercholesterolemia. May not the rabbit, a herbivorous animal, respond more violently than the carnivorous dog to sudden massive cholesterol feeding because of the stress placed upon his lipid metabolism in which the cholesterol load is normally low. May not the Eskimo tolerate his fish oils with impunity now because of a long past process of natural selection, allowing survival only to that metabolism which could accommodate such a restricted diet.

As our western civilization has progressed and prospered there has certainly been an increased consumption of rich foods high in fats and cholesterol. But along with our so called progress many other factors have been introduced which undoubtedly influence directly or indirectly the incidence of atherosclerosis. That prolonged severe dietary restriction is not the ultimate answer to the problem of atherosclerosis is now generally recognized by most investigators in the field. While a diet of moderation should be encouraged in the atherosclerotic patient there is as yet insufficient evidence to support those advocates of severe dietary restrictions either in prophylaxis or treatment. Indeed few patients are inclined or willing to live out their days on a semi starvation diet in the hope of adding a few weeks or months to their lives. It is doubtful whether many of the war sufferers would elect to return to their diets of privation even with the assurance of greater longevity.

Eventually more exact knowledge of the pathophysiology, pathogenesis and treatment of atherosclerosis will be obtained through medical and biologic research.

EDGAR WOODY, JR., M.D.

I Am Thankful . .

I am thankful for my mother and my food and clothes. I am thankful for Sunday School and the boys who get me there and back. I am thankful for the C.P.* school—for Mrs. Allen and all the people that help me. I am thankful for the fireman at No. 12 that helps me in and out of the car. I am thankful for my many friends. I am thankful for the ladies that bring me home from school. I am thankful for Fred who helps put me to bed every night. And aunt Anna, aunt Lois, uncle Ernest, Patty, Johnny and Wilie. I am thankful for the sunshine. I am thankful for the barber who comes to my home and cuts my hair. I am thankful for the Red Cross ladies that carry me to and from school. I am thankful for Jesus and his great and wonderful love. I am thankful for the birds and flowers that cheers us up.

JOEL VAUGHN (Age 14)

*Cerebral Palsy. Submitted by Dr. John B. Duncan, Director, Cerebral Palsy School, Atlanta. Letter written by pupil in C. P. School.

BY ANY OTHER NAME--

Apparently the insidiousness of proponents of the socialization of medicine is an inherent characteristic of the nature of the beast. As soon as the darkness in which they labor for the destruction of the foundation of American medicine is illuminated, these termites merely change their course and bore in more deeply after finding other areas of darkness.

Having been defeated at the hands of an enlightened American public by rejection of the Wagner-Murray-Dingell bill, the proponents have aimed their attack from a source less vulnerable to American opposition. Unless American physicians realize the potentialities of what occurred in Geneva, Switzerland in June 1952 at the meeting of the International Labor Organization, there exists an excellent possibility of our having socialized medicine without our knowledge and our consent.

Under the title "Social Security Minimum Standards Convention of 1952" which was passed by the International Labor Organization and voted for by all but one American delegates, is included the articles of "Minimum Medical Standards" which essentially calls for the Government members of International Labor Organization to provide complete medical coverage for all its inhabitants i.e., *socialized medicine*. This convention was submitted to 65 countries including the United States for ratification. Once ratified by any country, the convention becomes a treaty binding that country to its provisions. If one thinks otherwise, reference to our constitution, article VI, clause 2, provides as follows: ". . . all treaties made, or which shall be made, under authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the constitution or laws of any state to the contrary notwithstanding."

The convention establishes universal socialized medicine. Part two of the convention contains the following provision: The condition covered shall include any morbid condition, whatever its cause, and to pregnancy and confinement and their consequences. The benefits shall include at least—(a) in case of a morbid condition:

a. (1) General practitioner care, including domiciliary visiting; (2) specialist care at hospitals for in-patients and out-patients, and such specialist care as may be available outside hospitals; (3) the essential pharmaceutical supplies as prescribed by medical or other qualified practitioners; and (4) hospitalization where necessary and (b) in case of pregnancy and confinement and their consequences:

b. (1) Prenatal, confinement and postnatal care either by medical practitioners or by qualified midwives; and (2) hospitalization where necessary.

(2) The beneficiary or his breadwinner may be required to share in the cost of the medical care the beneficiary receives in respect of a morbid condition; the rules concerning such cost sharing shall be so designed as to avoid hardship.

(3) The benefit provided in accordance with this article shall be afforded with a view to maintaining, restoring or improving the health of the person protected and his ability to work and to attend to his personal needs.

(4) The institutions or Government departments, administering the benefits, by such means as may be deemed appropriate to encourage the persons protected to avail themselves of the health services placed at their disposal by the public authorities or by other bodies recognized by the public authorities.

The convention is a long one and has been quoted in part but reference to the *JAMA*, page 1574, August 23, 1952 will explain many of the issues involved. In any event this is state medicine and ratification by the American Government automatically imposes upon the American public government hospitalization, government physician-control and medication. It is almost inconceivable that a similar measure proposed by Oscar Ewing only recently defeated by our elected representatives is now presented again to these same representatives but cloaked in the clever disguise of social security. To offset this convention and its possible ratification, certain American statesmen have again rallied to the cause. Senator Bricker "will reintroduce (*JAMA*, page 13 January 3, 1953) his resolution for a constitutional amendment to prevent treaties from affecting the rights of American citizens as being contrary to the Constitution."

At the recent Denver scientific session the AMA House of Delegates voted to support the Bricker resolution. The physicians of Georgia must support the Bricker resolution if we are to avoid the catastrophic effects of treaty making which alters the laws of the United States and invests in an international organization in foreign powers any of the legislative, executive judicial powers invested in the constitution in the Congress, the President or the courts of the United States. A letter to the Georgia Senators and Representatives urging their support of the Bricker resolution is a privilege which we shall use.

PETER L. SCARDINO

*Controversies, Facts and Detection of**Preinvasive* **CARCINOMA** *of the***CERVIX UTERI**

The concept of carcinoma in situ has long been a matter of controversial opinion. The recent addition of exfoliative cytology to the armamentarium of cancer diagnosis has made it possible by its routine application to diagnose carcinoma in situ at an increasing rate. The observation of numerous patients, amounting in our own laboratory to more than 400 cases of carcinoma in situ, has contributed somewhat to the understanding of this phase of carcinoma. At the same time it has created additional problems which require further studies.

Controversies

One of the fundamental controversies is whether a carcinoma in situ should be regarded and treated as a carcinoma. Does it in every case develop into an invasive carcinoma, and if so, in what length of time does this change occur? Are there factors which may determine the course of a carcinoma in situ lesion and produce such changes which will effect invasion, control the rate of progression or possibly cause regression? Is any influence exerted by age, race or infections? What are the procedures of detection and diagnosis of an in situ lesion?

Validity of Concept

Although the number of cases which have developed from preinvasive to invasive carcinoma are accumulating in the literature, the exact evaluation of such cases is difficult. A correct diagnosis of carcinoma is possible only when the whole cervix is available for serial sections. Specimens obtained by single biopsies alone allow solely an evaluation of the extent of carcinoma within the area removed. Invasion may be present in other parts of the cervix. Therefore, any case of progression reported by histo-pathological

observation should be accepted with certain reservations. Although it is doubtful whether every case of carcinoma in situ turns into an invasive carcinoma, it is reasonable to assume that every case of invasive carcinoma has gone through a carcinoma in situ phase. The evaluation regarding the duration of time necessary for the transformation of an in situ lesion to an invasive carcinoma is difficult since the histological pattern does not indicate how long a carcinoma had been present at the time of diagnosis.

Period of Transition to Invasion

Previous attempts were made to determine the period of transition by subtracting the average age of patients with preinvasive carcinoma from the average age of patients with invasive carcinoma which revealed a figure of about 10 years' difference.^{1,2} The average age of patients with invasive carcinoma is computed on the basis of cases brought to diagnosis by symptoms, while the average age of patients with carcinoma in situ depends entirely on the type of patients, age groups, social strata and method of diagnosis. The average for preinvasive cancer can be changed drastically if the number of cases diagnosed in different decades of life alters. On the surface it appeared from our material that the highest incidence of carcinoma in situ was in the decade of 30 to 40. However, after relating the number of cases detected to the total number of patients examined in each decade of life, it became apparent that the prevalence of carcinoma in situ was equal, that is .8 per cent in every decade of life.³

Thus little can be added to the clarification of the rate of transition from an in situ lesion to invasive carcinoma. A number of cases studied by local physicians with slides submitted to our laboratory developed to an invasive carcinoma in periods of one to three years, while others were observed for longer periods without any change, or with signs of regression. However, the increase in the number of invasive cases of cervical carcinoma with advancing age and the constant prevalence of carcinoma in situ in each decade suggests that either more cases develop to invasion in the older age groups or that the transition to invasion is shorter in the older patients. On the other hand, carcinoma in situ in the younger patients may regress to normal, or patients may die from intercurrent diseases.

Note: This study was supported in part by a Cancer Control Grant from the National Cancer Institute, National Institute of Health, United States Public Health Service. Acknowledgment is due to Dr. T. G. Peacock and members of his staff for their interest and support of the cancer detection program carried out in the Milledgeville State Hospital.

Possibility of Reversion

In view of an earlier report,³ that failure of ovulation with protracted estrogen activity was frequently present and accompanied by menstrual disorders in patients with carcinoma in situ, it is suggested that spontaneous reversion in the younger patients may be possibly due to the potential ability of the ovaries to re-establish a normal pituitary-ovarian relationship with ovulation and episodes of progesterone activity to counteract the protracted estrogenic stimulation to the cervix.

Infections and Racial Factors

Not infrequently the fact of cervical infection is brought into relationship with cervical carcinoma. Recently Gagnon⁴ made an extensive study on records of 20,000 nuns and found only a negligible incidence of cervical carcinoma. On the basis of this finding he concluded that cervical infection may present the etiologic factor for carcinoma of the cervix. However, this conclusion is purely speculative since no examination of nuns was carried out. In addition, cervical infections occur quite frequently in women with intact hymen, by anal contamination or excessive hormonal stimulation to the cervix without mechanical introduction of a pathogenic agent from outside.

The low incidence of cervical carcinoma in certain races does not add much to the elucidation of this problem. It has been postulated that the rare occurrence of cervical carcinoma in Jewish women may be due to the fact that Jewish men are circumcized. However, the Arabs are also circumcized, while the women have a high incidence of cervical carcinoma. The fact that the Arabs are circumcized at puberty and not at birth as the Jews does not seem to be relevant.

Role of Pregnancy

For a long time pregnancy was considered as one of the etiologic, contributing or accelerating factors of cervical carcinoma. At first the trauma of birth was thought to be the responsible factor. Later it was suggested that the excessive hormonal stimulation to the cervix during pregnancy may produce atypical growth changes leading to carcinoma. Some doubt was cast on this question by observations recently reported³ which revealed a high incidence of nulliparous women and women with only one pregnancy who had developed cervical carcinoma. Furthermore, a study on the time interval between the last pregnancy and diagnosis of carcinoma was investigated which revealed a duration of 10-25 years. If it were true that pregnancy exerts any influence on the development of cervical carcinoma one would expect to find the last pregnancy at a more recent date prior to the diagnosis.

Diagnosis of Cervical Carcinoma in the "In-Situ Phase." Exfoliative Cytology

The diagnosis of cervical carcinoma should be attempted at a stage when the lesion is in the in-situ phase. This, from our experience, which covers the screening of over 50,000 women, is solely possible by routine examination of the whole female popula-

tion. The method of choice for this is the cytological study of exfoliated cells introduced by Papanicolaou.⁵ Carcinoma in situ in the white population can be brought to diagnosis by this method at a prevalence rate of 0.8 per cent. Eighty per cent of such cases are asymptomatic.

Exfoliative cytology permits the differential diagnosis between a carcinoma in situ lesion and invasive carcinoma with a certain amount of accuracy. In our material a diagnosis of carcinoma in situ was correct in 84 per cent. The remaining 16 per cent were cases of invasive cancer. Invasive carcinoma is being diagnosed with an accuracy of 94 per cent.⁶ There is as yet no explanation as to why exfoliated cells differ according to the type of lesion, while in the histological sections no cytological difference between carcinoma in situ and invasive carcinoma may be apparent. A possible explanation is offered to the effect that the chemical constituents of the cell differ and thus the two types of cells undergo different changes following exfoliation.

Biopsies and Endocervical Scrapings

Notwithstanding the diagnostic possibilities of exfoliative cytology, it is very strongly recommended that the final diagnosis should under no circumstances rest on cytological findings alone. Multiple biopsies should be taken in every case in order to evaluate the type of lesion and possibly the extent of invasion, which in 16 per cent of cases does not become apparent in the exfoliated cells. Furthermore there is one group of exfoliated cells which derive from the superficial epithelial layers, if found without additional cells from lower layers, is in only 50 per cent of cases associated with a carcinoma in situ. Intraepithelial anaplasia is, in the other 50 per cent of cases, responsible for the cellular changes on the surface of the epithelium.

Also biopsies may not infrequently fail to reveal the complete extent of the cervical carcinoma. Thus endocervical scrapings may not infrequently add to the diagnosis and particularly reveal invasion which may escape a biopsy.^{7 8} In view of the fact that a preinvasive carcinoma may be limited to a very small area, a negative biopsy in the presence of a positive cytological report should not be considered as final diagnosis, but should be followed by repeated endocervical smears and biopsies. The same applies to a negative smear in the presence of cervical lesions. A suspicious lesion should be biopsied in spite of a negative cytological report.

Observations of Carcinogenesis

In addition to the detection of definite in situ lesions of carcinoma of the cervix, exfoliative cytology appears to offer a method par excellence for the study of early lesions which indicate a tendency to the development of a carcinoma. Cells exfoliated from such lesions reveal certain abnormalities. Spontaneous reversion or progression can be closely watched by repeated smears in such cases. In our laboratory 14 such cases were studied over one and one-half to three years. In this manner, progressive changes in cell morphology were observed from

benign nuclear changes to definite preinvasive cancer cells, and in three cases, to early invasion.⁹

Conclusion and Summary

In conclusion, it is reasonable to assume that every case of cervical carcinoma develops through a stage of carcinoma in situ. As such it can be detected by routine screening with the use of exfoliative cytology. The prevalence of carcinoma in situ is equal in all decades of life. The duration of time in which an in situ lesion turns invasive is as yet problematical. It appears, however, that the rate and frequency of transformation to invasion may increase with age. The role of pregnancy in carcinogenesis of the cervix is questionable according to the findings presented.

The morphology of preinvasive cancer cells differs from those of invasive carcinoma. Thus carcinoma in situ may frequently be recognized by exfoliative cytology. The importance of biopsies and scrapings for the final diagnosis cannot be sufficiently stressed. The role of exfoliative cytology in the observation of benign cellular changes which may eventually develop

into cervical carcinoma has been described. It is thus possible to diagnose in such cases a carcinoma in situ in its earliest stage of development.

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RESOLUTION

by

MUSCOGEE *County Medical Society*

Whereas, the members of the Muscogee County Medical Society are cognizant, that, under the Constitution and Laws of the United States, each citizen is dutifully liable to military service in defense of this nation, and

Whereas, it is recognized that the burden of military service should be equally shared among all citizens, in so far as they are able to perform such duties, and

Whereas, the Muscogee County Medical Society realizes that scrupulous honesty and utmost impartiality must be shown in drafting of Doctors into the armed services.

Now, therefore, be it resolved that the Muscogee County Medical Society go on record as being opposed to the designation of any member of the Society as being essential, regardless of the nature of his practice, until such time that purely numerical considerations require deferment of individuals.

Be it further resolved that the following regulations be observed when the name of any individual is brought before this Society for the recommendation of essentiality of that member: (1) Prior notification of the entire membership must be given before such a recommendation can be considered by the Society; (2) The voting on such a personal matter must be by secret ballot; (3) A two-thirds majority of the total active membership shall be required to recommend that an individual member be considered essential.

Be it further resolved, that a copy of this resolution be sent to the District Advisory Committee and the State Medical Advisory Committee, in the hope that it will act as a guide and example in actions of the various committees and medical societies throughout the state of Georgia.

Editor's Note: This resolution was passed recently by Muscogee County Medical Society.

Congenital

ADRENOCORTICAL INSUFFICIENCY

Adrenal cortical insufficiency in the newborn has been recognized and reported with increasing frequency during recent years. The diagnosis is not always easy. When accompanied by genital change, as in female psuedohermaphroditism or macrogenitosomia in the male, it may be quite obvious, but in those infants exhibiting no evidence of excess androgen production and in whom the family history gives no clue, it may be obscure. Nevertheless, the symptom complex is sufficiently characteristic to suggest the possibility of the disease.

Laboratory data will usually confirm the diagnosis, which is strengthened by favorable therapeutic response.

Chart 1 is an attempt to briefly outline the accepted theory as to the physiology of the adrenal cortex. This is an adaptation of a chart prepared by Wilkins¹³ and adds the clinical manifestations which may be observed when there occurs an excess or diminution in production of the various known hormones.

It has been definitely established that the disease

Chart I
ADRENOCORTICAL HORMONES

TYPE STEROID	PHYSIOLOGICAL ACTION	CLINICAL MANIFESTATIONS		LABORATORY FINDINGS
		Hypofunction	Hyperfunction	
Desoxycorticosterone	Serum sodium increased Serum potassium decreased Water retention	Vomiting-cyanosis Diarrhea-dehydration Shock-death		<i>Hypofunction</i> Low serum sodium High serum potassium
Gluconeogenetic or 'S' Factor Compound E and/or F	Amino acid → CHO Blood sugar increased Liver glycogen increased	Hypoglycemic crisis Shock-death		<i>Hypofunction</i> Hypoglycemia
Androgens Protein Anabolism 'N' Factor	Tissue growth Sexual hair—both sexes Seborrhea and acne	Feminization	Virilization	<i>Hypofunction</i> Low urine 17 - Ketosteroid <i>Hyperfunction</i> High urine 17 - Ketosteroid
Estrine—both sexes Estradiol	Feminization		Feminization Gynecomastia	Urine: Increased estrin excretion
Progesterone	Progestins Changes in breast and endometrium			Urine: Pregnandiol excretion

Read before the One Hundred Second Annual Session of the Medical Association of Georgia, Atlanta, May 12, 1952.

under discussion results from the absence or reduction in production of the hormone controlling sodium and potassium metabolism and fluid balance. Rarely it appears that the primary disturbance is in the hormone concerned with carbohydrate metabolism. Excess androgen production usually accompanies electrolyte and water imbalance.

Histologically, the adrenal cortex is divided into three easily distinguished components, namely, the zona glomerulosa, zona fasciculata and the zona reticularis or fetal zone. There is no real proof that any one of the adrenal steroids is secreted by a specific type cell; however, attempts have been made to correlate the two. Especially has certain evidence seemed to point to the reticular zone as the probable origin of androgens. In this connection it is interesting to note that the adrenal gland of the newborn infant is relatively very large, being about .2 per cent of the entire body weight at birth, whereas the weight of the gland in the adult represents only .01 per cent of the total body weight. This enlargement has been shown to be due primarily to the greatly increased zona reticularis or fetal zone. The function of the fetal zone in the normal infant has not been proven to be androgenic in nature, however it has been suggested that the zone produces androgens which counteract the maternal estrogens flooding the fetus. To support this theory one might expect an increase in 17-ketosteroid urinary excretion in the neo-nate, but such has not been found to occur; whereas in adrenocortical insufficiency in the new-born infant accompanied by virilism or macrogenitosomia urinary 17-ketosteroids are increased, and there is an abnormally thickened fetal zone of the adrenal cortex.

Due to the peculiarities in the development and histology of the adrenal gland in the early weeks of life, it has been suggested by Jaudon⁶ that these infants may exhibit a temporary adrenocortical insufficiency in which there is nausea, vomiting, dehydration and possibly collapse, accompanied by excessive loss of sodium, chloride and water. He has found that blood studies reveal a moderate reduction in CO₂ combining power, some elevation of NPN and a normal to low sodium. He claims these babies are greatly benefited by the administration of sodium chloride, desoxycorticosterone (DOCA) and water. Subsequently it is possible to omit therapy without a recurrence of symptoms.

Although the existence of a temporary adrenocortical insufficiency in the neonatal period has not been definitely proven, the theory is interesting and merits further study. Its relation to the subject under discussion is doubtful. Certainly most of the case reports of true adrenocortical insufficiency indicate that the deficiency in hormone production is probably a permanent one, which will require continuous replacement therapy.

Butler, Ross and Talbot¹ in 1939 first reported a case of probable adrenal insufficiency in an infant with the now well recognized history of vomiting, diarrhea, dehydration, grayish cyanosis and collapse.

The laboratory investigation in this case revealed a lowering of blood sodium and chloride with an increase in potassium and NPN. The response to increased sodium chloride intake and adrenal cortical extract was prompt. Macrogenitosomia was not noted until the infant was two months of age. Eleven years after their original paper a progress report was made on this patient. During the first three years of life his growth was retarded. There were many episodes of respiratory and digestive disturbance. From three to seven years there was considerable acceleration of growth, but since that time growth has practically ceased. Epiphyseal fusion, which generally occurs at about 17 years of age, took place when the child was seven years old, resulting in dwarfism. The skeletal growth followed roughly the genital pattern; by seven and one-half years not only penis but testes were adult size. At nine years of age there was a heavy growth of pubic and axillary hair, a light beard and some recession of the scalp hair line. Throughout this child's life it had been necessary to continue the administration of sodium chloride and DOCA.

Wilkins, Fleischman and Howard¹² in 1940 reported their patient with adrenal cortical hyperplasia who suffered a typical adrenal crisis on the withdrawal of salt from the diet. At autopsy the adrenal glands were found greatly enlarged and to be composed almost entirely of the elements of the reticular zone of the gland. The enlarged testes were shown to consist of aberrant tissue resembling cells of the reticular zone of the adrenal cortex.

Subsequently, an increasing number of case reports have appeared in the literature including that by Thelander and Cholfin¹⁰, whose patient suddenly died as the result of infection in what apparently was an adrenal crisis, and Darrow's² case which exhibited evidence of macrogenitosomia at six months of age. Skelton's⁹ report included the pathological findings in an infant dying of adrenocortical insufficiency at age of six weeks. Although the adrenals exhibited great hyperplasia there was no evidence of the adrenogenital syndrome.

Dijkhuizen and Behr's⁴ paper brings out the fact that this disease may be familial. Case histories of two brothers are given who died within the first few weeks of life in adrenal crises. One of these infants exhibited an anomaly of the genitalia, the other showed no evidences of increased androgen activity.

Levine, Barnett and Tepper's⁷ case revealed evidence of adrenocortical insufficiency from birth. At one month of age the penis seemed large. This infant has done well on the usual therapy but virilism has become an increasingly disturbing factor.

Dreamer and Silver's³ report suggests certain points of interest. They cite the case history of one patient who at four years of age had never exhibited the adrenogenital syndrome and whose electrolyte and water imbalance appeared to be of a milder degree than usually encountered. Indeed at four years of age, it was possible to omit replacement therapy.

A striking example of the familial occurrence of

the disease is the case histories of three brothers treated at Egleston Hospital⁸, all of whom exhibited evidence of adrenocortical insufficiency and died in adrenal crises. One of these infants responded well to adrenal cortex extract and sodium chloride and lived to be six months of age. At autopsy the third infant revealed the typical findings of congenital adrenocortical hyperplasia. Unfortunately, these infants died before the present plan of therapy had been well established. Had they had the benefit of our knowledge of today they very likely would have survived.

Geppert's⁵ infant indicates that there may occur a deficiency of the carbohydrate controlling hormone of the adrenal gland resulting in intractable hypoglycemia and death without apparent disturbance of electrolyte and water balance. His patient revealed no evidence of genital change.

White and Sutton's¹¹ patient, however, which exhibited evidence of "S" hormone deficiency did show the adrenogenital syndrome.

The incidence of congenital adrenocortical insufficiency is probably much more common than was originally thought, as is indicated by the increasing number of case reports.

The diagnosis is dependent upon the history, symptomatology, physical findings and certain pertinent laboratory data. It is strengthened by favorable therapeutic response.

The family history may be revealing. A story of the death of a sibling accompanied by vomiting, diarrhea, cyanosis and collapse during the neonatal period should put one on guard. A history of pseudohermaphroditism or macrogenitosomia in the males is quite suggestive. Although these infants may appear normal at birth they rarely progress satisfactorily. From the beginning there is generally a story of anorexia, failure to gain, vomiting at times with occasional loose stools. Cyanosis may be noted immediately or may be a later manifestation. Vomiting is often projectile in nature simulating pyloric stenosis; indeed surgery has been performed thinking obstruction at the pylorus existed. Large amounts of parenteral fluid fail to restore hydration unless certain specific therapy is also instituted. Finally, in the more severe forms of the disease, without proper treatment, death ensues within a few weeks or months due apparently to circulatory collapse.

The presence of genital change indicating increased androgen production may be most helpful in arriving at a diagnosis. In the female there is usually pseudohermaphroditism although the condition has been reported in girls without genital change. In the male macrogenitosomia may be present at birth or may appear within a few months; formerly many of these infants died before this change was manifest, and in the future it may be that the judicious use of cortisone will prevent its development. None of our cases has thus far shown definite evidence of the adrenogenital syndrome, however the oldest in the present group reported is

only 12 months. Deamer's report of the four-year-old boy who exhibited rather mild evidences of adrenocortical insufficiency is the oldest case on record in which no genital change was noted.

Chart II

CONGENITAL ADRENOCORTICAL INSUFFICIENCY

LABORATORY DATA

Serum Sodium. Decreased—primary effect of decreased "salt water" hormone.

Serum Potassium. Increased—primary effect of decreased "salt water" hormone.

Urinary 17 KS. Increased—in cases with hyperplasia of fetal zone and excess androgen production.

Blood Sugar. May be decreased if "S" hormone is deficient.

Chlorides. Decreased—secondary effect.

NPN. Increased—secondary effect of dehydration and decreased renal blood flow.

CO₂. Decreased—Acidosis probably principally due to excess sodium loss greater than chloride loss.

Chart 2 shows the important laboratory findings which are believed to be pathognomonic of the disease. The most striking changes observed in the blood are the low sodium and high potassium levels, with marked hemoconcentration. In those infants suffering with "S" hormone insufficiency dangerous and intractable hypoglycemia may occur. 17-ketosteroid urinary excretion is found increased at times, especially in those infants exhibiting the adrenogenital syndrome. In those rare instances of adrenocortical insufficiency in which the deficiency in the "S" hormone is the important factor, the urinary excretion of 11-oxycorticosteroids tends to be low.

It is not uncommon to find low values for blood chlorides and CO₂ combining power and an increase in NPN of blood. These latter changes probably are secondary to the primary imbalance in electrolyte, fluid and glucose metabolism mentioned above.

Finally, if therapy fails the diagnosis is confirmed at the autopsy table. Grossly the adrenal glands appear greatly enlarged weighing as much as 12 to 15 grams each. They are brownish-tan in color rather than the normal yellow. The gland is composed almost entirely of polyhedral granular cells with eosinophilic staining properties typical of the reticular zone. The zona fasciculata and zona glomerulosa may be clearly defined but greatly diminished in size, or may be absent.

Chart 3 outlines the therapy which is generally accepted today and which was followed with minor variations in our four cases. In addition to the obvious need for fluid, glucose and electrolyte replacement, the administration of adrenal cortical extract during crises may prove life saving. As indicated in the chart, large doses of this product may be required to restore fluid, dextrose and electrolyte equilibrium, thus preventing complete circulatory collapse.

Chart III
CONGENITAL ADRENOCORTICAL INSUFFICIENCY

TREATMENT	
	DOSAGE
Adrenal Cortex Extract ACE	As much as 5-10 cc. Several times daily I.M. or I.V. May be life-saving in crisis.
Desoxycorticosterone Acetate DOCA	2-4 mg. daily. *I.M. in oil. *Sub-lingually. *Pel- let implantation. Calculate to give 60- 75% of daily injected dose. 100 mg. pellet will supply 0.3 mg. of hor- mone daily.
Sodium Chloride Na Cl	1-3 gm. daily. Parenterally in crises. In formula later.
Cortisone	Infants: 6.25 mg. daily I.M. 12.5 mg. daily orally. Patients over 8 yrs.: 25 mg. daily I.M. 50-75 mg. daily orally.

The dosage of DOCA is subject to regulation in each individual and, as a rule, is in the range of 2 to 4 mg. daily. Initially and during periods of stress the need may be greater. DOCA may be given intramuscularly in oil, in the form of sublingual pellets, or as pellets implanted subcutaneously. According to Wilkins, 60 to 75 per cent of the determined daily intramuscular dose is sufficient when supplied by pellet implantation. One 100 mg. pellet furnishes .3 mg. of DOCA.

The amount of sodium chloride added usually varies from one to three grams daily, but must be individually determined in each case. Often during the initial period of study and during crises sodium chloride must be supplied parenterally. Later it is given directly in the infant's formula.

Initial treatment with cortisone, according to Wilkins, should begin with relatively large doses, and when suppression of androgen production has occurred the proper minimal maintenance dose is determined. In infants this authority suggests 6.25 mg. intramuscularly daily and slightly larger doses orally. In our patients we determined 12.5 mg. daily in two cases as the ideal oral dose.

Chart 4 gives a brief summary of the pertinent family history, clinical manifestation and laboratory findings in the four cases presented in this paper. Although the typical symptoms of adrenal cortical insufficiency seem to have made their appearance at three to five weeks of age, none of these babies progressed from birth as well as the normal infant. Appetite was usually poor and gains slow. Vomiting occurred occasionally and was frequently accompanied by mild diarrhea. The symptomatology was strikingly similar. Cases 1 and 2 showed typical changes in sodium and potassium blood levels and responded dramatically to therapy. The laboratory data was not diagnostic in Case 3, however symptomatology and therapeutic response seem definitely to confirm the diagnosis. It is our belief that this infant suffers with a less severe degree of adrenocortical insufficiency than was encountered in Cases 1 and 2. However, after several months when a reduction in the amount of DOCA and sodium chloride was attempted there was a recurrence of diarrhea, some anorexia and loss of weight.

It would seem that Case 4 is similar to Geppert's infant which apparently suffered with a deficiency of the carbohydrate controlling hormone rather than that of the electrolyte-fluid hormone. Unfortunately, no 11-oxycorticosteroid studies were obtained on this infant; however, very low blood sugar levels were observed, and during crises we believe that death was prevented on more than one occasion by the use of large doses of adrenal cortical extract

Chart IV
CONGENITAL ADRENOCORTICAL INSUFFICIENCY
SUMMARY OF CASE REPORTS

Case	Age of Onset Weeks	Vom.	Diar.	Cyan.	Shock	Wt. Loss Lbs.	Sibs.	NA Meq/L	K Meq/L	NPN Mg %	Urinary 17 - KS Mg/24 hrs.	Blood Sugar Mg %
1	3rd	++	++	++	+	2½	1 dead at age 2 mo. Vomiting. Diarrhea. Cyanosis. 7 normal.	111	5.8	42.5	2.0 - 7.1	—
2	3rd	++	+	++	+	1¼	2 dead at age 6 wks. Vomiting.	126	7.8	75	—	106
3	4th	+	+	—	—	agin poor	1 normal.	136	4.1	—	0.7	—
4	5th	++	++	++	+++	1¼	2 normal.	140	—	41	1.0 - 0.3	31

intravenously. Although this patient is now on no specific therapy it is likely that during periods of stress, such as infection, it will be necessary to resume adrenal cortical extract and glucose intravenously.

REPORT OF CASES

Case 1—C.P. This white male patient came to Henrietta Eggleston Hospital at the age of eight weeks with the chief complaint of vomiting and "not doing well." He was the result of the tenth pregnancy. Two male siblings had died, one at eight months of meningitis and one at two months with history of vomiting, failure to gain, and sinking spells with grayish cyanosis, in one of which he expired. All other siblings are apparently normal.

The patient weighed 7 lbs. 8 oz. at birth. He was on breast one month, never nursed well but vomited frequently. At one month of age he was hospitalized elsewhere and given parenteral fluids. He was then put on formula, but one week later began to vomit every feeding and have eight to 10 watery green stools daily. His course was steadily downhill in spite of efforts to correct vomiting and diarrhea. He was referred to us on July 5, 1951, weighing 5 lbs. 1 oz. or 2½ pounds below birth weight.

The physical examination on admission revealed a very emaciated, dehydrated male infant with a feeble cry, practically no subcutaneous fat, skin loose, dry and doughy, eyes soft and sunken, fontanelle sunken with overriding of the cranial bones. There was noted to be excessive hair extending down on face laterally and the penis was moderately enlarged. The evening of admission he was put on a weakened formula of Alacta.

The following morning blood chemistries showed serum sodium 111.0 Meq/L, serum potassium 5.8 Meq/L, serum chloride 80 meq/L; RBC 4,430,000; Hgb. 15.4 gms; WBC 22,600; P. 82, L. 15, E. 3; urinalysis, albumin 2 plus, a few cellular elements and granular casts. He was given plasma 50 cc, normal saline 250 cc. I. V. and S. C. and 5 per cent glucose in distilled water 150 cc. Two cc. adrenal cortex extract was administered and cortisone 6.25 mg. every six hours was begun. Five per cent glucose in normal saline was started by mouth. Fluids the following day were 300 cc. glucose in normal saline, 200 cc. glucose in distilled water and 50 cc. plasma. Desoxycortioesterone acetate 1 mg. intramuscularly was given and cortisone was continued. The third day therapy was continued and condition seemed improved. On the fourth day the baby suddenly began the passage per rectum of very large amounts of dark and bright red clots and liquid blood. This continued until it seemed that he would surely exsanguinate. During that day and night he was given 450 cc. of whole blood but as the bleeding continued and condition was fairly satisfactory a laparotomy was performed. At this operation no specific point of bleeding was seen although the entire tract below the ligament of Treitz was filled with blood. The diagnosis of peptic ulcer was entertained but not proven. The abdomen was closed and, fortunately, the bleeding stopped. Fluids and blood were mentioned. Cortisone was omitted until the wound healed and then resumed at 25 mg. daily.

DOCA was increased to 2 mg. daily, subcutaneous and I. V. fluids supplying 2 gm. of sodium chloride were continued. The formula was changed to protein milk. Small gains were obtained by adequate caloric intake, Amigen solution parenterally, and as much as 3 grams of sodium chloride in form of normal saline. Three weeks after admission DOCA was increased to as much as 4.5 mg. daily but in two weeks the baby had become edematous. Additional blood chemistry determinations showed a serum sodium 140 Meq/L and potassium 2.9 Meq/L. An EXG showed low E. M. F. At this point it was felt advisable to decrease DOCA, cortisone and sodium chloride. Subsequently, a satisfactory dosage was found to be 2 grams sodium chloride in formula and DOCA 2 mg. daily. The baby's weight gain was fairly steady and he began to look much improved. Four months after admission, at which time he weighed 10 lbs. 4 oz. and seemed well regulated on 3 grams sodium chloride, 4 mg. DOCA and 12.5 mg. cortisone daily, five pellets of DOCA, 75 mg. each, were implanted subcutaneously in the mid-axillary lines. Daily DOCA was stopped immediately.

He continued to do well. Sodium chloride was cut to three and then to two grams daily. At eight months of age, while still in the hospital he experienced a modified attack of measles without undue incident. At this time we were able to get urinary 17 ketosteroid excretion values. The first determination was done while he was taking 12.5 mg. cortisone daily and was 2.0 mg/24 hrs. After this, cortisone was stopped and subsequent 17 keto-steroid levels obtained were 16 and 34 days later showing respectively 4.6 and 7.1 mg/24 hrs. Cortisone was resumed at 12.5 mg. daily.

At the age of nine months he weighed 19 lbs., was on evaporated milk formula, usual foods including cereal banana, fruit, egg, vegetables and meat. He was alert, intelligent, lovable, normal appearing baby, beginning to pull up and crawl.

He was discharged to home on sodium chloride 2 grams daily and cortisone P. O. 12.5 mg. daily. He has continued to do well on home treatment.

Case 2—J. W. This five and one-half weeks old white male was admitted with the chief complaint of vomiting. The family history revealed two siblings who died at six weeks of age, with history of vomiting. There is one sibling living and well at age of two and one-half years. This baby, apparently normal at birth weighing 7 lbs. 12½ oz., began to vomit occasionally the third day of life. In the third week of life he began to vomit after each feeding. Stools were yellow, soft and two to three daily. Vomiting continued and he was admitted to another hospital for four days. For three days before admission at Henrietta Eggleston Hospital he had received 1 cc. lipo adrenal extract daily and parenteral fluids.

Physical examination on admission revealed a baby weighing 6 lbs. 8 oz. or 1 lb. 4½ oz. below birth weight. There was very little subcutaneous fat, skin turgor was decreased, anterior fontanelle somewhat depressed and the penis appeared rather large. There was a definite gray duskeness.

Laboratory studies on admission revealed Hgb. 20 gm., RBC 4,500,000; WBC 9,900, P. 42, L. 56, E. 2, NPN 75 mg. per cent; serum sodium 126 Meq/L, potassium 7.8 Meq/L, fasting blood sugar 106 mg. per cent, urine normal.

Parenteral fluids were given and Alacta formula was started. Vomiting occurred two or three times a day for the first four hospital days. On the seventh hospital day, cortisone 25 mg. bid was begun and parenteral fluids continued. The baby developed some edema and cortisone was reduced to 25 mg. daily. He gained weight and showed considerable improvement. Stools were good but he vomited one to two times daily. On the twenty-sixth hospital day DOCA 1 mg. daily was begun and the sodium chloride increased from 1 to 2 grams daily. By this time the baby had gained 1 lb. 2 oz. over admission weight.

Formula was now evaporated milk, and cereal and fruits were added. The baby continued to do very well, weight gain was consistent and he was sent home on DOCA 1 mg. daily, sodium chloride 1 gram in formula. Cortisone had been omitted. At the time of discharge on the fifty-eighth hospital day, he weighed 10 lbs. 12 oz. (gain of 4 lbs. 4 oz.). The last serum potassium was 4.1 Meq/L. Urinary 17-ketosteroid determinations were not done. He did well at home for a while. However, during an acute respiratory infection he apparently went into adrenal crisis and died away from the hospital. Autopsy was not obtained.

Case 3—R. J. This white male was admitted to Henrietta Eggleston Hospital at the age of three months with complaints of diarrhea, vomiting and failure to gain. He was the result of the third pregnancy, there having been a miscarriage and a sister now living and normal who is two and one-half years of age. The birth weight was 6 lbs. 12 oz. This patient was essentially normal for the first four weeks of life but during the fifth week began vomiting. This became worse in spite of numerous formula changes and two periods of hospitalization. Also, at intervals, there was diarrhea which became marked during the tenth week so that parenteral fluids were required.

The physical examination on admission was essentially normal except for moderate malnutrition and questionable genital enlargement. He weighed 8 lbs. 8 oz. Admission laboratory studies revealed RBC 2,600,000, Hgb. 10 gm. WBC 10,900 with P. 84 per cent, L. 15 per cent, E. 1 per cent; stool film test positive for trypsin; urinalysis negative except

for a trace of albumin; serum concentration of sodium 136.4 Meq/L and potassium 4.1 Meq/L.

Parenteral fluids including whole blood and glucose in normal saline were administered. The baby vomited three or four times daily and had green watery stools. On the third day after admission desoxycorticosterone acetate 1 mg. daily was started and sodium chloride 2 grams was added to the Alacta formula. The vomiting and watery stools ceased abruptly. Eight days later the formula was changed to evaporated milk, and in the next 16 days the baby gained 14 oz. On the twenty-eighth hospital day DOCA was increased to 1 mg. bid, cereal and vegetables were added to the diet. Cortisone 25 mg. daily was started on the twenty-third hospital day and cut to 12.5 mg. daily on the thirty-fourth day. He was discharged on the fortieth day, weighing 10 lbs. 4 oz., on evaporated milk formula with sodium chloride 2 grams, cereal and vegetables. DOCA 1 mg. bid and cortisone 6.25 mg. bid were to be continued. He did well on this treatment at home. A urinary 17-ketosteroid excretion level was 0.7 meq/24 hr. while cortisone was being given, which was at the same level after cortisone had been omitted. However, when an attempt was made to reduce the amount of DOCA the baby became anorexic, vomited and had loose stools. The administration of DOCA in the usual amount was resumed and the baby improved.

Case 4—B. F. This white female infant was admitted to Henrietta Eggleston Hospital at the age of eight weeks with complaint of diarrhea and weight loss. She was the result of the third pregnancy and two siblings were perfectly normal.

This baby weighed 7 lbs. 7 $\frac{3}{4}$ oz. at birth. She vomited intermittently and stools were always more frequent than normal and had mucous. When six weeks of age she was hospitalized because of malnutrition, dehydration and weight loss of nearly one pound. In the hospital she was given various formula changes, antibiotics, fluids and blood transfusions. For the week before admission she had been given $\frac{1}{4}$ cc. lipo adrenal extract daily. She continued to vomit and have loose stools, six to 10 daily.

On admission she weighed 6 lbs. 4 oz. or 1 $\frac{1}{4}$ pounds below birth weight. She was found to be a marasmic infant crying weakly, the skin very dry and with poor turgor, having a grayish appearance. The abdomen was slightly distended. With the exception of these findings the physical examination was essentially negative. The genitalia were not abnormal.

The day following admission she was given parenteral fluids and Alacta formula. About 48 hours after admission she had the first of repeated episodes in which it seemed that she would surely expire. She was cyanotic, pulse slow, irregular and weak. At this time she was given 5 cc. of adrenal cortex extract with remarkable improvement.

Blood chemistry studies by the next day were not too striking, showing NPN of 41 mg. per cent, chlorides 613 mg. per cent, blood sugar 79 mg. per cent; serum sodium 140 Meq/L, potassium not obtained due to laboratory error, and a stool film test for trypsin was positive. A urinary 17-ketosteroid excretion was 1.0 mg/24 hr.

She was started on 2 mg. DOCA and sodium chloride 2 grams in form of normal saline subcutaneously. However, her course was progressively downhill and loose stools continued. DOCA was increased to 3 mg. and sodium chloride reduced because of possibility of causing loose stools. About 10 days after admission she again had a very severe crisis after an eight-hour period of starvation in preparation for G. I. Series. At that time color was poor, respirations irregular and shallow, and a blood sugar determination was 31 mg. per cent. She was again given Darrow's Solution parenterally and an almost immediate improvement was noted. A serum potassium the next day was 3.1 Meq/L and an EKG showed low T waves and low EMF compatible with hypopotassemia. Therefore, the patient was given Darrow's Solution parenterally as well as other fluids and adrenal cortex extract, 2 cc. intramuscularly and 2 cc. in I. V. fluids. Later she was started on potassium chloride 0.25 grams bid, orally.

DOCA was stopped for a while, adrenal cortex extract given instead and she was maintained largely with parental fluids for the next several days. Another serum potassium in three days was 5.4 Meq/L and a repeat EKG in one week

was improved. She continued to have crises which were relieved by adrenal cortex extract. A severe respiratory infection developed and x-ray showed atelectasis of right upper lung.

Fluids and adrenal cortex extract 5 cc. daily and/or DOCA up to 3 mg. daily were continued and the respiratory infection treated with antibiotics and oxygen. Fortunately, the chest cleared and the baby began to improve on Nutramigen formula and adrenal cortex extract 5 cc. bid plus DOCA 1 mg. bid. 17-ketosteroid determinations were 0.3 mg/24 hr. on two occasions. The weight curve was very erratic; after seven weeks of struggle she was one pound over admission weight.

On March 3 an I. V. glucose tolerance test (given 0.5 gm/kg in 5 per cent solution) showed 126 mg. per cent fasting, 135 mg. per cent in one-half hour, 99 mg. per cent in one hour, 106 mg. per cent in two hours and 100 mg. per cent in three hours. She received adrenal cortex extract 2.5 cc just before this test was begun and had been starved for nine hours prior to that time. The infant slowly improved while on adrenal cortex extract 5 cc. twice daily, DOCA 1 mg. twice daily and sodium chloride orally 2.0 grams daily. After continuing this schedule for several weeks while the child gained and continued to do well, the medications were gradually reduced and discontinued; first adrenal cortex extract was stopped, then DOCA and finally sodium chloride. She continued to do well and was discharged.

Summary and Conclusions

We have presented four cases of varying types and degree of congenital adrenocortical insufficiency. Apparently the electrolyte studies do not always furnish absolute evidence of the disease, especially in those cases exhibiting sub-total deficiency of the electrolyte controlling hormone.

Case 4 indicates that a deficiency of the carbohydrate controlling hormone alone may exist. In these infants replacement therapy may be needed only during crises.

Macrogenitosomia thus far has not developed in any of our four cases, which supports Wilkins' concept of prevention of the adrenogenital syndrome by administration of cortisone.

It seems likely that congenital adrenocortical insufficiency occurs more commonly than has been suspected. Infants presenting unexplained respiratory and gastrointestinal symptoms accompanied by marked dehydration and circulatory collapse should promptly suggest this disease. Adequate laboratory investigation will usually confirm the diagnosis. Specific therapy may produce dramatic improvement. Maintenance therapy may provide normal growth and development.

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A Practical Consideration of

THROMBO-EMBOLISM

T

hrombo-embolism is an ever threatening complication encountered by surgeons and internists alike. Frequently a patient who has apparently recovered from an illness or operation, and is making ready to return home, may suddenly die from pulmonary embolism. Such a tragedy has occurred in the experience of practically every surgeon. In spite of the attention directed to this problem in the past 15 years and the outstanding contributions by investigative and clinical workers, it has in no wise been eliminated and in fact it may even be increasing in frequency.

Very briefly, let us review the most plausible concept of intravascular clotting as recently advanced by Quick.^{1 2} He postulates the liberation of a labile factor (thromboplastin) from disintegrating platelets, which initiates a chain reaction terminating in clot formation. For our purpose, we can pass over the details and accept the hypothesis that a thrombus must begin with clumping and breaking down of platelets. Normal endothelium does not permit thrombosis, but even minor disturbances such as pressure, trauma and local anoxia from stasis can quickly alter this property of endothelium and provide a focus for the accumulation of platelets and the resulting thrombus formation. From such a coagulum, a serum rich in thrombin is squeezed out; and, if the circulation is active, this is washed away, diluted. If the circulation is sluggish, further thrombus forms at the tip of the clot, and propagates down stream. Such an intravascular clot may remain attached only at its base, forming the so-called phlebothrombotic clot, with few manifestations and fre-

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quent embolism on detachment. On the other hand, the clot may, by occluding the lumen of the vein, give rise to extensive intimal damage with resulting firm attachment, producing thereby the typical thrombophlebitic clot with associated pain, arterial spasm and edema.

Detailed autopsy studies have clearly demonstrated that thromboembolism in the vast majority of instances has its origin in the tibial veins and their tributaries below the knees where intravascular clotting is favored by stasis. With this for a working basis, we can state that any factors favoring intimal damage and stasis in the leg veins may eventuate in thrombosis. As to these factors *per se*, we may enumerate the more common ones.

1. Age—About 80 per cent of all cases occur in patients above 40, 60 per cent above 50.

2. Obesity—Said to increase the likelihood by 50 per cent.

3. Anemia—Probably much more important than is generally considered; because in its presence, clot retraction is faster, and more pronounced.

4. Heart disease—Relatively high incidence.

5. Prolonged immobilization—Even bed rest for a few days is possibly hazardous.

6. Operations—Especially prolonged pelvic procedures, or those carried out for visceral malignancies.

7. Personal or familial history of previous vascular disease.

AMA Annual Meeting

Hardly is the debris swept away from one AMA meeting when it's time to plan another . . . especially, when the next annual meeting of the Association is expected to top all previous records.

As early as last spring, AMA headquarters staff men settled preliminary arrangements with contractors, truckers, decorators and convention hall officials for the *June* meeting to be held in *New York City*.

During the first part of January, more than 5,280 square feet of exhibit space will be sold to approximately 350 commercial firms. Space has been allotted on the first three floors for the Technical Exposition and on the fourth floor for the Scientific Exhibit.

More than 12,000 hotel rooms in New York have been pledged for the convention. Physicians planning to attend the meeting may make their reservations as soon as the hotel advertisement appears in the *Journal of the AMA*.

8. Other lesser factors such as dehydration, trauma, burns, and even anxiety seem to influence the development of thrombolism.

The incidence of embolism from thrombosis in the leg veins is recorded as about 10 per cent which is probably a conservative figure. In view of present effective measures for treating established venous thrombosis, the problem of embolism would not be so great except for the disconcerting fact that emboli, particularly fatal ones, most frequently occur when the underlying thrombus is unsuspected. To date, we have at hand no precise means for determining susceptibility or diagnosing subclinical thrombosis. This is actually the crux of the entire problem at the moment.

To review briefly what has been done toward the prevention of pulmonary embolism, we recall the initial work of Homans,^{3 4} who first advocated femoral vein interruption, a procedure that was later championed by Allen.^{5 6} Large groups of patients have had both therapeutic and prophylactic femoral vein ligations, with a striking reduction in the incidence of pulmonary embolism. Then, with the advent of the anti-coagulants, heparin, dicoumarol and later tromexan, a further reduction has been effected. To some extent, the adoption of early ambulation in surgical patients has played a definite role. However, as it is usually employed, in the majority of instances, it is but little more than a gesture. For ambulation to be effective, the patient must actually walk, preferably during the initial 24 hour period, and not many of them can do that. Merely sitting the patient up with his legs dangling over the edge of a chair may even favor development of thrombosis. Paravertebral lumbar block, as advocated by Ochsner, is now used more in the treatment of the thrombo-

phlebitic type. Only in a general way can we comment on the two major measures cited above. They have their respective places, both prophylactic and therapeutic.

At the present time, the anti-coagulants are used more widely, even by former proponents of vein interruption, the latter being used primarily in those cases demanding positive measures where the use of anti-coagulants is contraindicated. For obvious reasons, neither lends itself to mass prophylactic employment. Physical and financial reasons alone preclude such, especially in small institutions. Furthermore, there are certain inevitable complications, especially from dicoumarol, that cannot be dismissed. From the practical standpoint, therefore, we have two measures at our disposal; early diagnosis and prompt treatment; and secondly, the systematic screening of our patients directing more attention to those we consider most likely to develop thromboembolism. In the first category, we certainly can, through vigilance, pick up many cases of early thrombosis in bed patients, and by prompt institution of anti-coagulant therapy, vein interruption, or a combination, as dictated by the circumstances, reduce the incidence of embolism to an almost negligible figure, and lessen morbidity. Bauer,⁸ in Sweden has a most impressive series in which during a nine year period, the mortality rate from pulmonary embolism was only 1.3 per 10,000 patients, as a result of early diagnosis and prompt heparinization alone. We must not only examine the legs for tenderness and swelling each day, but we must educate our personnel to be on the alert for any complaints of leg pain. Allen^{5 6} has long emphasized the significance of a slight increase in the pulse rate and temperature curves.

On the other hand, all too frequently, the first indication is the appearance of a pulmonary infarct which, if small, may be manifest only by a complaint of mild chest pain. Any of these signs and symptoms invite immediate investigation in order that effective therapy may be instituted without delay. Our preference at the moment is heparinization alone, or in combination with dicoumarol. The only major drawback to heparin is its expense. Dicoumarol must be used more cautiously, and the dosage controlled by very accurate prothrombin determinations. Where anticoagulants are contraindicated for clinical reasons, or in the absence of reliable laboratory service where dicoumarol is indicated, venous interruption should certainly be carried out without delay. As for the second approach, we suggest the utilization of the system worked out by Smithwick of grading patients according to the presence of factors known to increase the incidence of thrombus formation. In such a scoring system, he considers that any patient with a total of six or more points should be considered susceptible and watched very carefully, and, in some instances, given the benefit of prophylactic anti-coagulant therapy, or even with ligation. Smithwick⁹ has also advocated the employment of elastic stockings

in bed patients as a preventive measure, and recent reports by Mixer are very encouraging. We may also add to this the use of elevation of the foot of the bed for postoperative patients. Only by employing such a system of grading for all out-patients over 40 requiring bed rest, can we institute prophylaxis and such additional measures as we feel are indicated. We may then effect a definite reduction in the incidence of this disastrous complication. This treatment, combined with a real alertness for the earliest possible manifestations of venous thrombosis should result in the prevention of numerous fatal pulmonary emboli.

Factors and Numerical Grade
(From Farmer and Smithwick)

1. Age 50 or More.....	3
2. Major Abdominal or Pelvic Surgery.....	3
3. Presence of Cancer.....	2
4. Serious Post-Op. Complication	2
5. Prolonged Operation (3 hours)	2
6. Obesity	1
7. Varicose Veins	1
8. Abdominal Distension	1
9. Infection, Part, Intrab.	1
10. Shock, D, & A. Operation	1
11. Prolonged Immobility	1
12. Heart Disease	1
13. Blood Dyscrasia or Anemia	1
14. Dehydration	1
15. Prev. Thromboembolic Dis.	1

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DISCUSSION

DR. PATRICK SHEA, JR. (Atlanta)—The subject of thromboembolism has been, is, and will always be, a timely topic wherever doctors are assembled. As Doctor Talmadge has so carefully pointed out, alertness is an all important factor in the treatment of this grave complication of medical and surgical hospitalized patients. As he also has demonstrated, ultimate therapy is a matter of choice with a preponderance of physicians utilizing the anticoagulants, rather than peripheral venous ligation, a point with which I am in complete agreement. I would like to point out also that it is my firm belief that the incidence of thrombosis and embolism has not increased but, rather the alertness of the physician has increased the frequency of the diagnosis, which explains the multitude of papers and presentations of the subject.

There remain—the dreadful, initial fatal pulmonary emboli without premonitory signs with which we are unable to cope. The hoped-for value of DeCamp's and Ochsner's antithrombin test has proven to be a failure. Some day, I am sure, we will have some laboratory evidence of actual or impending venous thrombosis so that treatment may be instituted before fatality occurs. Careful evaluation of the patient from day to day frequently reveals the signs of early phlebothrombosis.

It has been a most pleasurable experience to me to see medical students recognize the disease before our house staff has an opportunity. The students, in their daily rounds and ward work, spend a great deal of time with a few patients while the individual house officer who is held in the clinic and operating room for long hours may not see the patient when the telltale signs first arise.

As Doctor Talmadge has mentioned, tenderness and swelling over the effected vein are the most reliable signs. Early, there may be no increase in temperature and pulse—Homans' sign, is apt to be misleading. Therapy should be instituted at once, as soon as the diagnosis is indicated and it is only by alertness and early therapy that we can defeat thrombo-embolism. As has been mentioned in many other reports, careful technical surgery, good hemostasis, prevention of prolonged periods of low blood pressure, are all important in the prevention of this dangerous complication.

February Landscape

This might have been the last outpost of time,
This cold world stretching where the mountains climb
In sudden whiteness shouldering the wind;
This might have been the world's swift, frozen end.
Yet, hand in hand, taking the slopes together,
We scuff the soft snow upward, the sharp-flaked
weather
Pecking our faces, giving us crowns to wear
Of frozen pearls along the morning air.

Let us walk softly here, our steps half heard,
Nor frighten any furry creature or bird,
Nor brush an avalanch of snow from trees
Stirring the air with crystal symphonies.
Warm hand in hand, sure-footed, let us go
Lightly as shadows across the deepening snow,
Remembering that a word might break the spell,
Shatter this February miracle.

Daniel Whitehead Hicky

MORTALITY *in* PEPTIC ULCER

Hemorrhage

The problem of hemorrhage from peptic ulcer remains today as in the past an ever present challenge to the medical profession. Though there has been gratifying improvement in the past decade in managing this ulcer complication; there still remains much controversy as to the proper therapeutic methods to be applied. More than 8,000 people³ die annually from the complications of peptic ulcer and hemorrhage is a major contributor in this toll.

It will be the purpose of this presentation to discuss briefly some of the controversial points in the management of hemorrhage from peptic ulcers; also to outline a method of approach which may further reduce the mortality from this condition.

In reviewing this subject it is difficult to compare the figures of different writers because of the variable definition of hemorrhage. Some writers include a wide variety of cases while others include only the most serious bleeders. This difficulty in comparison has recently been recognized by many writers^{5, 2, 3} and it is urged to define hemorrhage or massive bleeding as blood loss of sufficient amount to produce signs of shock. Though this definition will not be all inclusive, if it is followed we can compare our results.

As recently as 12 years ago, Holman² reviewed the literature and found an acceptable mortality in massive hemorrhage from peptic ulcer to be around 25 per cent. Then as now, there is considerable variation in different reports; but in the current literature a mortality rate of around five to six per cent is average. This is a very gratifying improvement to have occurred in a single decade. After considering the many variations in the outline of treatment, there seem to be three factors which have been largely responsible for this improvement. These factors are:

- (1) More adequate attention to nutritional requirement of the patient.

- (2) Proper and adequate blood replacement.

- (3) Integration of surgery into the problem of management.

In 1935 Meulengracht⁴ reported a 2 per cent mortality in the management of bleeding ulcers. This unbelievably good result was attributed to immediate feeding of the bleeding ulcer patient. It has been said, that the patients were advised to wipe the blood from their lips and to eat beef steak. Although no American worker has been able to equal Meulengracht's results, this focus on the nutritional requirements of the patient has been a definite therapeutic improvement. It should be remembered that at the time of this report the accepted treatment was to give nothing by mouth and nothing intravenously. The patient was given fluids by subcutaneous clysis. Most patients who die from bleeding ulcers do not die immediately. They usually bleed in varying amounts for over a week before death. Holman² reported an average of 13-16 days between first hemorrhage and death. If the patient is starved for this period of time, insult is being added to injury. Following the report of Meulengracht, the literature was literally loaded with reports of various feeding routines and the improvements resulting therefrom. Perhaps one of the best known of these was the hyperalimentation technique of Co Tui.¹ In this regimen, a gastric tube was passed into the fundus of the stomach and the patient was given a constant drip of a high protein mixture containing various other ingredients. At the present time, the logical method seems to be frequent feedings of a liquid or bland diet, high in protein content. Probably the most satisfactory diet is 100-200cc of protein-fortified milk given at 30-60 minute intervals during the day and similarly at night when the patient is awake. This preparation can be kept cooled at the bedside and can be given by a member of the family or the nurse in attendance. Not only does this feeding technique give the patient needed energy food factors, but also favors healing of the ulcer.

Until relatively recently it was deemed most unwise to give a patient blood during the active phase of bleeding from an ulcer. The apparent logic behind this misconception of treatment was as follows: If blood is given the blood pressure will be elevated and if this occurs the clot will be blown out and further hemorrhage ensue. It was considered ideal to maintain the patients just above deep shock levels. A frequently used routine was to give the patient 10cc of blood from a syringe every 30 minutes in an effort to replace blood without elevating blood pressure. More recent experience has taught us that it is far better and more physiologically sound to promptly bring the patient out of shock with an amount of blood necessary to accomplish this end. Improved mortality figures indicate that elevation of the blood pressure is not an added risk to the patient. Sustained shock with its accompanying anoxia is far more serious than the risk of further bleeding. If

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bleeding recurs in any magnitude or repeatedly after blood replacement, we are then dealing with a surgical problem.

Gastric resection at a time of election following two or more ulcer hemorrhages is an established surgical principle. In a patient with such a history, there is about 50 per cent chance for additional and more serious bleeding. The possibility of an emergent gastric resection during the active phase of bleeding has been a more recent development. This latter procedure has unquestionably reduced the overall mortality rate in bleeding peptic ulcers. When we read today of more than 100 consecutive gastric resections without an operative death, it is hard to believe that only 15 years ago this procedure carried a primary surgical mortality of 10-15 per cent. Better anesthesia, proper use of blood, better understanding of fluid and electrolyte balance, and the antibiotics have been largely responsible for this improvement. The only significant change in surgical technique has been a greater familiarity with the procedure as we do more of them. The type of resection done and the anastomosis is essentially the same as 25-30 years ago. The most important single factor in the successful surgical care of these emergency cases is closely coordinated team work in the operating room and during the immediate post operative period. As the risk of this operation has diminished, surgeons have become increasingly bold in using it during active bleeding. The improved results seem to have justified this boldness.

I know of no more difficult problem than attempting to determine when to operate on a patient who is actively bleeding from a peptic ulcer. Each case is different and the decisions are genuinely a life and death matter. Small wonder that surgeons may hesitate to become involved in such a risky matter. If the surgeon takes over and death ensues, it is the surgeons fault. If death follows delay, the patient can be said to have died of natural causes. Although each of these cases is different, experience has taught us that certain patterns are present and certain general principles can be formulated. The most important of these principles is this: We can operate on these patients in shock provided we have enough blood on hand. The shock can be easily reversed after the bleeding has been stopped with a ligature provided we do not wait too long. We have also learned that it is not necessary to remove the ulcer in every case. This should be done unless it is deemed unnecessarily risky. In such cases the duodenum can be closed proximal to the ulcer and the usual resection done. Although such patients may have additional bleeding after operation it is usually limited and recovery is the rule.

Now let us consider some of the indications which our experience seems to have justified. The following indications favor early or emergent operation during active bleeding from a peptic ulcer.

(1) Bleeding which cannot be controlled by conservative measures. It seems unwise to delay any definite number of hours. Whether the delay is two hours or 72 hours depends on the amount of blood loss and the patient's response to this loss.

(2) Massive bleeding which recurs following a temporary improvement of a day or two.

(3) Massive bleeding which occurs in a patient under hospital management for some other ulcer complication.

(4) Massive bleeding accompanied by rather intense and unremitting pain.

(5) Because of the greater risk, patients over 45 years should be operated earlier than patients under this age.

These indications give us some basis for action. The underlying principle is this: we should stop bleeding by direct surgical attack before shock has become irreversible and before tissue anoxia has produced irreparable damage. If we reserve surgery as a last desperate move our results will remain poor. Experience has taught us certain signs of grave things to come. If we recognize these and operate early our results may continue to improve.

For the purpose of speculation let us say that we could select those patients who would die from ulcer hemorrhage. If we operated on this 5 per cent (fatal group) early with even 10 per cent mortality rate, our overall rate would be $\frac{1}{2}$ per cent. We can't expect to do this. However, by using the principles outlined and the indications mentioned, we might include this fatal group by operating on 15 per cent of massive bleeders during the active phase of bleeding. Using the same mortality rate of 10 per cent, our overall mortality rate would then be around 1.5 per cent. In other words by early medical and surgical cooperation using the best known methods 85 per cent patients with massive bleeding from peptic ulcers will respond promptly to non operative management. Fifteen per cent will not respond promptly. These should be operated on early. With this cooperative approach, we might anticipate an appreciable reduction in our best overall mortality from 5 per cent to around 1.5 per cent. Just such a program as this was instituted at the Columbia Presbyterian Medical Center and reported by Porter, Harvey, and Schullinger.⁵ During one year they treated 76 cases of massive hemorrhage from ulcer. Eighty per cent of these responded to conservative measures. Twenty per cent were operated when they did not respond promptly. There was one surgical death or an overall mortality rate of 1.3 per cent. In this report two factors were stressed. First was the close cooperation between the medical and surgical services. Second, those cases that did not stop bleeding on non-operative measures were treated surgically without further delay.

Peptic ulcer is a benign disease which will usually respond to good medical care. The complications of this disease are amenable to surgical attack with fairly satisfactory results.

In any non-malignant disease which will respond to direct therapeutic approach we should not be satisfied until our mortality approaches zero. Peptic ulcer is such a disease. Until we understand the complicated psychosomatic problem that is the ulcer patient, surgery will remain a useful therapeutic

agent. By a closer cooperation between medical and surgical attendants we can hope to further reduce our mortality in the bleeding ulcer patients. Surgical treatment should not be reserved as a last desperate measure, but should be used earlier in the case of hemorrhage when conservative measures fail.

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Relapsing Febrile Nodular Non-Suppurative

PANNICULITIS (*Weber-Christian's Disease*)

*Report of a Case with Autopsy Findings**

Relapsing febrile nodular non-suppurative panniculitis (Weber-Christian's Disease) is characterized clinically by recurrent, painful red subcutaneous nodules associated with a relapsing fever, malaise and leukopenia. Eventually the nodules regress, leaving depressed areas in the skin. Histologically, the picture varies with the stage of the disease. In early lesions there is fat necrosis with edema, congestion and infiltration by polymorphonuclear leukocytes without suppuration. Later, macrophages appear and ingest the free fat, followed by fibroblastic proliferation and fibrosis. In a recent survey of the literature, Johnson and Plice⁶ found 35 cases and added one of their own. Bendel¹ also reviewing the literature, added several reports that had not been included in previous reviews. Since then other case reports have brought the total to approximately 50.

REPORT OF A CASE

M. C., a 51-year-old white female textile worker was first admitted to Emory University Hospital on August 23, 1943 at the age of 45 years, complaining of the onset six months previously of tender, reddened tumors over both parietal areas with alopecia of the overlying scalp and associated anorexia, progressive weakness and low grade fever. Within a two month's period the hair began to reappear in the areas of alopecia, and the hair distribution was normal at the time of admission. There were slightly raised, firm, tender subcutaneous tumors which were fixed to an erythematous overlying skin and measured up to three centimeters in greatest diameter. These tumors involved the bridge of the nose, both parietal areas of the scalp, both shoulders, the anterior abdominal wall and both thighs. A firm, smooth, slightly tender liver edge was felt one centimeter below the right costal margin, and the spleen was palpable at the left costal border. The white blood count varied from 4,500 to 6,250 per cmm. with an essentially normal differential. The red blood cell count was 3.6 million per cmm. and the blood hemoglobin content was 9.8 grams per 100 ccs. The erythrocyte sedimentation rate was 49 mms. in one hour (Westergren). Aspirated sternal marrow was within normal limits. Her temperature varied from 99.4 to 102 degrees F. for 10 days; she then became afebrile and felt generally improved at the time of discharge from the hospital.

She was readmitted three times prior to her final admis-

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sion, each time with the same complaints and physical findings. A biopsy of the subcutaneous nodules was reported as showing fat necrosis consistent with Weber-Christian's Disease. During these admissions the temperature varied from 99 to 101 degrees F., and the liver and spleen were moderately enlarged. The white blood cell count varied from 3,400 to 4,500 per cmm., and a sedimentation rate on one occasion reached 108 mms. in one hour (Westergren). On three occasions her blood cholesterol was 72 mgm per cent (44.4 mgm per cent esterified), 54.7 mgm per cent (32.4 mgm per cent esterified) and 50.7 mgm per cent (26.6 mgm per cent esterified), the fatty acids were 8.8 millimoles per liter, and the phospholipids 5.8 mgm per cent. On two occasions there was 10 per cent BSP retention 45 minutes after a dose of 5 mgm/Kg. The thymol turbidity was 6.5 units, cephalin flocculation 4 plus after 48 hours, and total protein 6.4 grams per cent of which 3.7 grams per cent were albumin. Blood cultures were always sterile.

On her final admission in October 1949, she was found to be emaciated and dehydrated. No new subcutaneous nodules had appeared and those over the forehead and manubrium sterni had disappeared. The liver was palpable four cms. below the right costal border, while the spleen was felt two cms. below the left costal margin. The red blood cell count was 3.9 million per cmm., the blood hemoglobin 10.3 gms., and the hematocrit 32 ccs./100 ccs. The white blood cell count was 1800 per cmm. with 6 metamyelocytes, 80 polymorphonuclear leukocytes, 8 lymphocytes, and 6 monocytes. The blood cholesterol was 125.6 mgm per cent and the non-protein nitrogen was 31 mgm per cent. Each night the patient became disoriented and incontinent, and on her fourth hospital day had a generalized convulsion followed by coma and a temperature rise to 104 degrees F. Shortly after the convulsion an indwelling catheter was inserted into the bladder. Following the convulsion, it was noted that she had a right facial weakness, rigidity of the left arms, a positive Babinski's sign on the left, and she subsequently developed a complete flaccid left hemiplegia. Lumbar puncture revealed an initial pressure of 40 mms. of spinal fluid. The fluid was clear, colorless and contained 2 lymphocytes per cmm. She had a second convulsion on her sixth hospital day, lapsed into a coma and died on the ninth hospital day.

Therapy during periods of admission consisted of a high vitamin, high caloric diet supplemented with intravenous glucose and amigen; gold sodium thiosulfate was administered on one occasion with no apparent benefit. Penicillin and aureomycin had no effect on the fever.

Gross Autopsy Findings

Autopsy was performed two hours post-mortem. The body showed evidence of considerable weight loss. There was moderate generalized icterus. Scattered over the arms, forearms and abdomen were various sized poorly defined, firm subcutaneous nodules measuring from 2-4 cms. in greatest diameter. These nodules were oval in shape and attached to the skin. On cut surface, the masses were found to be non-encapsulated and composed of tightly packed, firm lobules of fat.

One hundred ccs. of clear yellow fluid were found in the pericardial cavity and 250 ccs. of similar fluid were present in each pleural cavity. The omental and peripancreatic fat appeared quite granular, and the mesentery, which was generally free from fat, showed multiple small yellowish nodules measuring as much as 5 mms. in diameter. A few enlarged lymph nodes were present in the region of the pancreas.

The liver weighed 2700 grams, and though symmetrically enlarged, presented a sharp edge. The smooth capsule transmitted a pale yellowish brown color. On cut surface the liver displayed a bright

yellow color and imparted a greasy sensation to palpation. The lobular architecture was well maintained.

The spleen weighed 400 grams and, except for moderate congestion did not appear remarkable.

The brain weighed 1300 grams and appeared moderately edematous. Examination at the time of autopsy and after fixation revealed no areas of softening or hemorrhage. The air sinuses of the skull and middle ears were not remarkable.

The heart, lungs, pancreas, adrenals, kidneys, thyroid, bone marrow, aorta and the internal genitalia showed no gross abnormalities.

Histologic Examination

Tissues were fixed with Zenker's fluid with 5 per cent glacial acetic acid and 10 per cent formalin USP, and stained routinely with hematoxylin and eosin. Selected sections were stained with phloxin-methylene blue, Gram-Weigert stain for bacteria, and Herxheimer's fat stain.

The nodules from the skin and from the omentum, peripancreatic fat and mesentery showed widespread fat necrosis and fibrosis. (Figs. 1, 2, 3.) In areas there was a diffuse infiltration of plasma cells

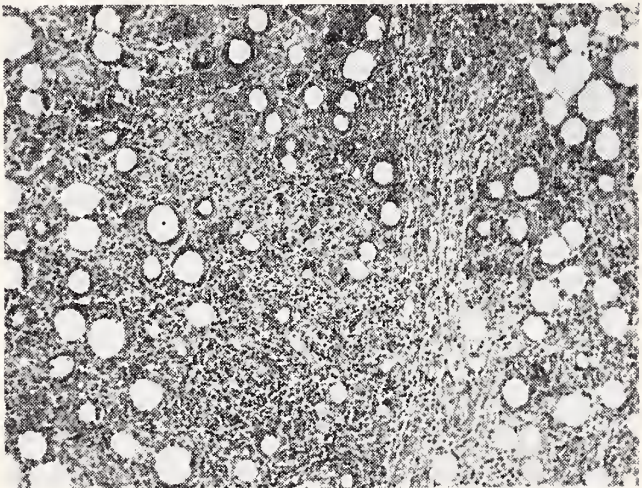


Figure 1. Low-power view of a nodule of mesenteric fat necrosis, showing fibrosis, chronic inflammation and foreign-body giant cell reaction. Hematoxylin and eosin X96.

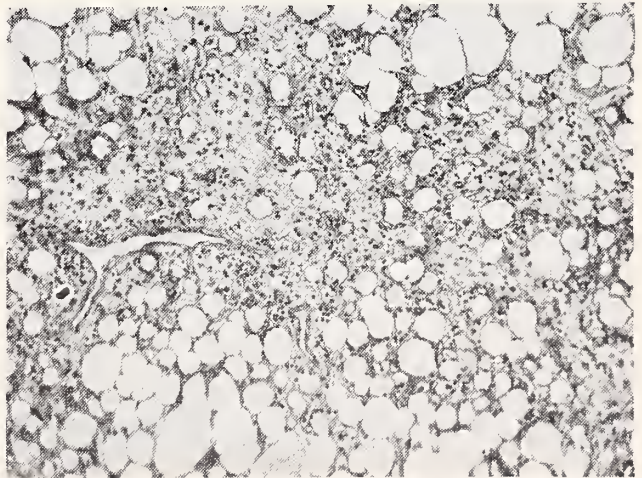


Figure 2. Area of mesenteric fat necrosis showing focal nature of the lesions and moderate lymphocytic and plasma cell infiltration. Hematoxylin and eosin X200.

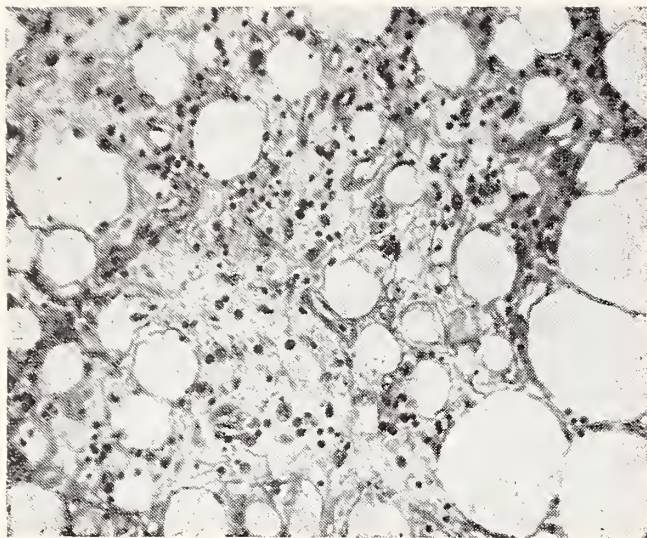


Figure 3. High-power view of the area shown in Figure 2. Hematoxylin and eosin X400.

and lymphocytes which thickened the connective tissue septa between the fat cells. In many areas, fat laden macrophages with foamy cytoplasm were present, and an occasional engulfed red blood cell could be seen. A few proliferating fibroblasts were found in these areas which also contained numerous thick walled arterioles. Although some of these arterioles were surrounded by chronic inflammatory cells, no true perivascular infiltration was seen. Strands of loose edematous collagenous tissue replaced the fat in some areas. Here, one could find only an occasional lymphocyte or plasma cell. Rare multinucleated giant cells were present. There were no areas of tissue breakdown or abscess formation. The skin over the subcutaneous nodules showed only a slight atrophy of the epidermis and was not involved in the inflammatory process.

Sections of the abdominal lymph nodes showed many areas of fatty infiltration with large numbers of foamy macrophages. A diffuse acute and chronic lymphadenitis was present in the lymph nodes around the head of the pancreas. The spleen was congested and large numbers of lipid-laden mononuclear cells were found within the red pulp.

Marked fatty metamorphosis was present in all of the liver sections. The parenchymal cells contained huge cytoplasmic vacuoles and in areas appeared atrophic. No true liver cell necrosis was seen and there was no increase in fibrous tissue. A moderate infiltration of lymphocytes was present in the portal spaces.

The urinary bladder showed a moderate acute inflammation throughout the wall with areas of hemorrhage and diffuse infiltration of polymorphonuclear leukocytes.

Sections of the brain showed a distinct purulent meningitis which appeared acute and diffuse. Large numbers of Gram negative rods were demonstrable in the meningeal exudate. An area of softening and necrosis was seen in the right motor cortex. This had the appearance of a recent lesion.

Sections of the thyroid gland, heart, lungs, kid-

neys, aorta, bone marrow, and internal genitalia did not appear remarkable. No fat emboli were demonstrated in any of the sections.

Post-mortem cultures from the heart's blood and lungs grew *E. coli*.

Anatomic Diagnosis

Relapsing febrile nodular non-suppurative panniculitis (Weber-Christian's Disease); fatty metamorphosis of liver; acute purulent meningitis; encephalomalacia; acute cystitis; and acute and chronic lymphadenitis.

The surgical biopsy from a subcutaneous nodule was reported on 9/10/46 by Dr. Walter Sheldon as follows. "The section shows skin and subcutaneous fat. The epidermis has a thin stratum granulosum. The dermis is quite thick and particularly in the deeper portion, shows a slight to moderate perivascular infiltration by lymphocytes and plasma cells. A similar cellular infiltration is present around some of the hair follicles. An occasional elongated oval focus of dense cellular infiltration of plasma cells and lymphocytes is seen in the deeper portion of the dermis around small blood vessels which show slight intimal thickening. One foreign body type giant cell is seen in one of these foci. The subcutaneous fat is for the most part, of normal appearance. However, in some small fibrous areas between the lobules of fat there are many giant cells with a moderate infiltration of plasma cells and lymphocytes. In most fat lobules scattered lymphocytes and plasma cells are seen, occasionally in small foci. In an occasional lobule large, sometimes multinucleated, lipid laden macrophages are located between the large fat cells. These macrophages, admixed with plasma cells and lymphocytes, tend to accumulate around each vessel in the involved lobule of fat. These changes are consistent with Weber-Christian's Disease." (Fig. 4)

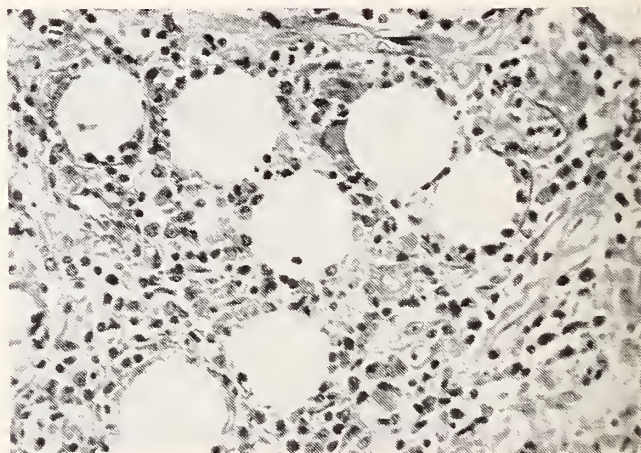


Figure 4. Photograph of subcutaneous nodule removed in September, 1946 showing extensive cellular reaction to focus of fat necrosis. Hematoxylin and eosin X400.

Comment

This patient had a clinical course consistent with relapsing febrile, nodular, non-suppurative panniculitis. She was moderately anemic and had a leukopenia with depression of all white blood cell elements. She had enlargement of the liver and spleen,

and liver function tests showed evidence of progressive functional impairment. There was an episode of icterus during her second year of illness. The blood cholesterol was extremely low on several occasions and was recorded as 50.7 mgm per cent two months before death. She had two generalized convulsions and developed a left hemiplegia shortly prior to death. No form of therapy appeared to influence the course of her illness.

This case of Weber-Christian's Disease brings the total number reported to approximately 50. Post-mortem examination of nine of these patients has disclosed that the pathologic process is not limited to the subcutaneous tissues. Involvement of the mesenteric, omental, pretracheal and peri-pancreatic fat was reported by Spain and Foley¹⁰ and epicardial, perirenal, peripancreatic and mesenteric nodules were found by Mostofi and Engleman.⁸ In addition, three of the cases have been reported to show non-specific fatty changes in the liver usually associated with central necrosis.^{10 8 7} Miller and Kritzer⁷ reported fat emboli in the lungs. Other findings have been hydropic degeneration of the adrenal cortex and reticulo-endothelial hyperplasia. In the cases described by Ungar¹² and Friedman⁴ a terminal bacteremia appeared to be the cause of death, while in the patient reported by Spain and Foley¹⁰ the cause was found to be chronic glomerulonephritis. Tilden et al¹¹ reported an apparent cure of Weber-Christian's Disease that later, at autopsy, was found to have disseminated tuberculosis. Hallahan and Klein⁵ reported another fatal case who died of Hodgkins Disease. Shuman⁹ also described a fatality in which cortisone therapy was instituted. This drug produced only a normal temperature for five days but had no effect on the course of the illness.

Theories as to the possible etiology of this disease are numerous. Many of the patients had taken halogens, and some showed regression of the nodules when the drug was discontinued. This prompted several authors to suggest the possible significance of bromides and iodides in the etiologic role. Foci of infection, avitaminosis and hypergy to drugs and allergens have been advanced as essential factors in the production of this syndrome. Brudno² recently reported a patient with Weber-Christian's Disease and suggested that this syndrome is allied to the group of collagen diseases. Duran-Reynals³ found that in sensitized rabbits the picture of Weber-Christian's Disease could be duplicated by the injection of a variety of non-specific substances as Brown-Pearce tumor, virus III of rabbits, bacteria and tissue extracts.

Our findings are in accord with those described in the literature. The inflammatory changes were not confined to the subcutaneous tissues, but were present in omental, mesenteric and peripancreatic tissues. A rather marked fatty metamorphosis of the liver was present and was associated with an enlarged spleen. A few abdominal lymph nodes showed moderate infiltration of fat. No fat emboli could be found in any of the organs. The biopsy sections,

three years before death, showed a less striking picture than the nodules obtained at autopsy. Although there was slight to moderate perivascular inflammation and numerous foci of chronic inflammatory cells, the tissue obtained at autopsy revealed widespread fat necrosis and replacement of the connective tissue septa by dense fibrous tissue. In neither the surgical biopsy nor the autopsy tissue was there evidence of acute inflammation.

An interesting, though incompletely explained, finding was the acute purulent meningitis. This could have been secondary to the encephalomalacia, but the acute cystitis and post-mortem cultures of *E. coli* suggest that the meningitis was the result of a terminal bacteremia. Extensive study failed to reveal cerebral fat emboli as the cause of the encephalomalacia.

Summary

A case of relapsing, febrile, nodular, non-suppurative panniculitis (Weber-Christian's Disease) is reported. This patient had numerous hospital admissions but was not benefited by any form of therapy. Post-mortem examination showed fat necrosis and inflammation characteristic of this disease which involved subcutaneous, omental and retroperitoneal fat tissues. Fatty metamorphosis of the liver was a striking feature. The patient died of a cerebro-vascular accident and concomittant purulent meningitis.

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Can YOU Retire, Doctor?

Recently a historian of a graduating class of the School of Medicine of Northwestern University, whose members now range in age between 66 and 75, made a sad report: Of the surviving physicians seven per cent are disabled, 63 per cent would love to retire but cannot afford it and only 30 per cent can enjoy a care-free retirement. Only 30 per cent after more than forty years of unremitting service to humanity!

But why? Dr. B. L. Riese of Berkely, California found two main reasons for this: poor investments and unstable speculation on the stock market. This should be ample proof that too many physicians feel they know how to invest wisely to secure a nest-egg for old age.

How easy it is, is related by Bernard Baruch, who made millions on the stock market: "If you are ready and able to give up everything else and will study the market and every stock listed there as carefully as a medical student studies anatomy, and will glue your nose to the ticker tape at the opening of every day of the year and never take it off 'til night; if you can do all that, and in addition have the cool nerve of a gambler, the sixth sense of a clairvoyant and the courage of a lion—you have a Chinaman's chance."

Similar ideas are expressed by the late U. S. Supreme Court Justice Brandeis in his book "Other People's Money": "The number of securities on the market is very large. For a small investor to make an intelligent selection from the many corporate securities, indeed, to pass an intelligent judgement upon a single one, is ordinarily impossible. He lacks the ability, the facilities, the training and the time essential to a proper investigation. Unless his purchase is to be little better than a gamble, he needs the advice of an expert, who combining special knowledge with judgement, has the facilities and the incentive to make a thorough investigation."

We usually associate the purchase of common stock with speculation, and with the hope of profit from an anticipated change of price. And yet, strangely enough, according to studies of the Stock Exchange, less than ten per cent of common stock owners engage in speculative buying and selling. As a matter of fact, conversation with numerous physicians brought out, that most of them primarily invest with thoughts of stable income and long-range appreciation especially now in view of an inflated dollar.

Prepared for the *Journal of the Medical Association of Georgia* by Dr. Robert Scharf, Asst. Professor, Department of Social Science, Georgia Institute of Technology.

But just now seems to be the time to remember the extreme fluctuations in basic industry stocks. Physicians who bought before 1929 in order to participate on a boom period in our country cannot forget that once they owned General Motors at a high of \$91.67 and at a low of \$7.62. It is a tragedy for anybody to see his Western Union stock go down from \$272.25 to \$12.37. And we cannot help thinking of that doctor who invested the savings of many years in 1000 shares of Chrysler stock at \$135 a share and saw it dwindle and fade away to \$5000.

Statistics are usually boring. But a study of the long-term price record of the country's leading common stocks between 1929 and 1941 ought to be impressive to anybody:

	High	Low
American Telephone & Telegraph Co.—per share.....	\$310.25	\$70.25
Dupont	231.00	22.00
General Electric	100.75	8.50
Republic Steel	79.50	1.87
Sears Roebuck	181.00	9.87
U. S. Steel	261.75	21.25
U. S. Rubber	72.37	1.25
Western Union	272.25	12.37
Woolworth, F. W.....	103.87	22.00
Westinghouse E. & M.....	292.62	15.62

How many people knew in advance of the tragic collapse of the stock market on that "black Friday" in 1929 and of the panic decline of September 3, 1946, the sharpest drop in stock prices since 1940?

Not only are the price fluctuations tremendous; it is also somewhat doubtful to rely on a stable and continuous income from annual stock dividends. A study of 1,236 stocks, all listed at the New York Stock Exchange, showed that during a period of ten years only 220 stocks paid dividends continuously.

Then maybe the purchase of bonds promises greater security. Indeed, most people think that bonds, government and industrial, represent exceptionally reliable income. However, two important factors affect the stability of this type of income: when interest rates decline generally, corporations or government units will call the old issue and re-finance it with a new issue at a lower interest rate and another factor is the uncertainty of the future attitude of government upon the taxation of bonds. And after a bond matures, the re-investment problem presents new difficulties. Therefore it is not without risk to think of bonds as good property.

Numerous doctors like to invest in real estate—

other than their home. Everybody knows of someone who got rich through speculation in real estate. But, many factors affect real estate values in the future. For instance, as a result of sudden changes in zoning ordinances, a good residential section may deteriorate in the future. Besides, many well-to-do people will own and use airplanes in the years to come, as we use automobiles today. They will live many miles away from their place of business and it will take them less time to reach it by helicopter than by driving through traffic jammed city streets. Land values may never enhance as expected. Government activity in the housing field will have definite effect on the value of residential property. Legislative rent limitations are still in everybody's memory. Last but not least, income from real estate fluctuates almost exactly with the great cycles of business activity.

Then, after all, what IS good property which will guarantee a stable old age income?

Lawrence Chamberlain, an authority in finance problems, has established a test, of good property. Here are his ten cardinal questions we should ask ourselves whenever we think of planning for future financial independence.

How secure is my principal? Does it yield a regular income? Does it yield a fair income? Can I sell it easily? Can I borrow against it? Is it tax exempt? Does it require constant care? Can it be bought in convenient units? Does it require re-investment? And what are the chances to make money?

If we apply these basic questions to stocks, bonds and real estate, the answers will not be too satisfactory.

But, how, then, can we wisely take care of our old age?

There is only one investment in existence with a guarantee clause attached; a good life insurance plan, issued by a good company which shows high cash values and liberal income options, an income which neither husband nor wife can outlive—provided we accept Chamberlain's test of good property.

Repeatedly raised by investors is the question of whether life insurance can be considered the primary key to an investment program, especially in view of the fluctuation in the purchasing power of the dollar. Let us, therefore, analyze the situation as to depression and inflation.

In case of a depression, insurance savings are doubtless superior to investments on the stock market. As soon as there are signs of an approaching recession even the best stock will considerably decline in price. So will most of the commodities, and in a similar proportion, as the cost of living will decrease, the purchasing power of the dollar will increase. But the cash value of a good life insurance policy, bought with easily earned dollars, is guaranteed and will place the policy owner in quite a favorable financial position. However, a business recession comes on rather suddenly and catches the non-professional investor quite unaware. When he, then, considers selling his stock, the institutional in-

Films Available

Fourth Supplement to Motion Picture Reviews Now Available

The Committee on Medical Motion Pictures of the A.M.A. has completed the fourth supplement to the booklet entitled "Reviews of Medical Motion Pictures." It contains all the film reviews published in *The Journal*, from January to December, 1952.

One copy has been mailed to the secretary of each state medical society. Copies are available to county medical societies on request from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10.

vestors will have already sold their holdings and the "outsider" is caught at a bearish market.

On the other hand, there is definitely no protection against a runaway-inflation of European style, as the study of the European investment market indicates. But the inflation, as we know it here, is a creeping disease. The cost of living has been going up since 1938 until our dollar arrived at a comparative purchasing power of about 52 cents today. Some goods and services went up 100 per cent and more since 1938. Let us assume, that we established an insurance estate to protect our family in case of death and to provide a retirement life income in case of longevity, some 12 years ago. When the cost of living went up some 100 per cent, it was merely a matter of consequence to increase our life insurance outlay in the same proportion. Then we shall have increased the amount of our retirement life income with 100 per cent and this would take care of the higher cost of living today accordingly. Unfortunately, some of us accepted the necessity of higher outlay for nearly everything, but did not pay the same attention to our insurance estate. Then, of course, we cannot blame the institution of life insurance for providing insufficient returns.

Last not least, it is by no means the intention of this writer to eliminate the stock, bond and real estate market as a medium of investment entirely. But it should not be forgotten, that the meaning of insurance is to "make sure" i.e. not to take a chance. If and when an economically sound life insurance program has been set up—and, then, there are still means left for other investments, it is not only patriotically imperative to buy government bonds, but also necessary from our capitalistic point of view to join the institutional investors like banks and insurance companies and to help our own industry to obtain working capital.

And yet—when we are old, we don't need so much money in the bank. What we need is an INCOME which neither we nor our wives can outlive.

Editor's Note: This is the first article in a series concerning financial investment and the physician.

General Aspects of

MATERNAL CARE

in GEORGIA

Georgia's maternal mortality record for the past 20 years may be reviewed at a glance in table 1. The increase in the number of live births by thousands, while the maternal deaths for each 1,000 live births decreased, has certainly reduced the risk of death from childbirth. Although these figures are excellent, they still are measurements in terms of death, whether the fatalities are unavoidable or preventable. We should be reaching the bottom of this crudely measured mortality, which, 15 to 20 years ago, we thought included only the unavoidable deaths.

At that time the puerperal fevers and the toxemias (eclampsias) accounted for approximately 66 per cent of the maternal deaths. Today, the toxemias (eclampsias), especially in the nonwhite race, loom up as one problem which still faces the profession. Many of the nonwhite mothers suffering from eclampsia are already multiparas many times over, whose yearly pregnancy results in dizziness and swelling caused by a profound hypertension or albuminuria which is relieved by a spontaneous miscarriage or a necessitated induction, far too early in pregnancy. The recurring yearly pregnancies of this type are devoid of live births. Eventually a maternal death is recorded while the list of orphans, with its potentiality for juvenile delinquency, swells. This problem exists and has to be faced. Is the answer hidden in the poor distribution of sterilization measures throughout the state? Why could not such a serious problem be faced and met on a new combined scientific and religious basis? A program of this type requiring funds, understanding, individualization and careful medical selection could be better handled by the Woman's Auxiliary to the Medical Association of Georgia on account of the medical aspect involved.

Clearing from the field the infections and the

eclampsias, representing 66 per cent, places in a magnified position today a smaller group of 15 to 20 years ago, namely, the deaths from hemorrhage and their management.

Tables 1 and 2 cover the historic transition in obstetrics in Georgia from the "surgical era" to the "drug era." In the surgical era, the forceps, cesarean section, pituitrin, anesthetics and some narcotizing "twilight sleep" were all innocent evils of a necessary nature, viewed from the advanced hindsight of today.

It took much education to swing us over into the

drug or conservative era of today. The surgical era, as it pertained to obstetrics, did not widen with the advent of the antibiotics and the much improved chemotherapy. Instead, the high and mid forceps deliveries have practically disappeared as well as the hurried, feared and forced births. We are in the drug era of relaxation in labor, whether it is produced psychologically or by means of a drug routine combined with the psychologic aspect. The national figures show a decrease in birth injuries (surgical era) and an increase in atelectasis (drug era). Could these statistics indicate too much drug in premature births?

Over a decade ago, the Committee on Maternal Care of the Medical Association of Georgia made a

Table 1
NUMBER OF LIVE BIRTHS AND MATERNAL DEATHS
BY RACE IN GEORGIA FOR 1930 AND 1951

Year	White		Maternal Deaths	
	White	Nonwhite	White	Nonwhite
1930	37,064	23,254	361	297
1951	59,285	35,876	46	97

Table 2
MATERNAL DEATH RATES PER 1,000 LIVE BIRTHS
BY RACE IN GEORGIA FROM 1930 THROUGH 1951

Year	Total	White	Nonwhite
1930	10.9	9.7	12.8
1931	10.0	8.6	12.1
1932	9.7	8.1	12.2
1933	7.6	6.4	9.4
1934	7.8	6.8	9.2
1935	7.2	6.2	8.8
1936	8.0	6.9	9.5
1937	7.4	6.3	8.9
1938	6.5	5.1	8.7
1939	5.5	4.5	7.0
1940	5.3	3.8	7.6
1941	4.6	3.2	6.9
1942	4.1	3.2	5.7
1943	3.9	3.0	5.4
1944	3.6	2.5	5.6
1945	3.3	2.2	5.4
1946	2.7	1.5	4.9
1947	2.6	1.7	4.4
1948	2.3	1.3	3.9
1949	2.0	1.2	3.3
1950	1.6	1.0	2.7
1951	1.5	0.8	2.7

check on the financial status of the patient in cases of maternal death. For normal deliveries, the ward patient fared much better than the private patient, while the reverse was true regarding abnormal deliveries. In this conservative or drug era of today, it is clearly the duty of the physician to gain the confidence of the anxiously waiting family and to educate them to a realization that a hurried and forced birth is an old-fashioned procedure carrying with it a high percentage of disastrous results.

Even excluding the inductions by cesarean section, the supposedly minor procedure of a radical old-fashioned birth is, in truth, a mighty one, whether it be by bag, bougie or membrane rupture. The indications for an induction of labor are fairly closely limited. When a bona fide medical reason exists for an induction of labor, less procrastination should be entertained. If this reason does not exist, however, a good sound hindsight should supersede a daring forethought. Even if no havoc results from the extensive and promiscuous employment of this procedure, an increase in the number of premature babies will surely follow.

Again, the induction of labor as a practice is poorly distributed throughout the 159 counties of Georgia. Some mothers die, undelivered, of eclampsia without its employment.

By way of illustration, the general practitioner induces labor on a primipara by rupture of the membranes and, in addition, the insertion of a bag. Luckily, the cord does not prolapse and the chin does not present. Because no labor ensues in 48 hours, he consults a specialist regarding cesarean section. The specialist advises against this procedure and urges upon him time and relaxation in labor. Several hours later, pituitrin, 3 to 4 minims at an injection, is employed to bring on contractions, the amount given totaling over an ampule. As soon as the cervix is

dilated, presumably completely, the forceps is used to displace the second stage of labor. The time elapsing from the first pain to birth is six hours. A 6 pound infant is stillborn.

Where is the labor? Labor in such a case does not exist. It is intruded upon by induction, pituitrin and forceps.

In contrast, a specialist requires 1 dozen minims of pitocin to deliver a multipara in spontaneous labor two months before term.

In both instances the mother survives; therefore, there is no addition to the maternal mortality figures except the threat of the potential death. The stillbirths, however, indicate that "old-fashioned births" are being brought forward to a "modern era." A physician, even if he does not keep up from month to month or from year to year, should at least keep up enough so that procedures are not carried from one era to the next.

The Committee on Maternal Care is confronted with these problems. It, therefore, will attempt to post small items of an obstetric nature above the scrub basins of the various hospitals throughout the state. This wide distribution of small bits of obstetric information will enable the physicians of Georgia to pick up ideas and will encourage thought and stimulate discussion while they are working. The purpose is to help those who are less fortunate in not having had the opportunity to receive postgraduate education as well as those who cannot afford time off for a refresher course. Any specific obstetric contribution or suggestion of an educative nature will be appreciated by the Committee. In this way, the Committee hopes to distribute advanced or new information to the physicians of the state, whether they are members or nonmembers of the Medical Association of Georgia.

This program is designed for the physicians by the physicians and is sponsored by the Medical Association of Georgia.

National Conference on AGING

GUY V. RICE, JR., M.D., Atlanta

Introduction

The increase during the past decade of the older age group in comparison to that of the total population is focusing national attention upon the problems of the aged. Fourteen states now have commissions or committees set up to work on varied aspects of the problems of the older age group. Florida, California, and Arizona have worked on

the problem with the particular interest, because many retired workers have migrated to these states to take advantage of their mild winters. Too often these persons have underestimated their cost-of-living needs versus their financial reserves, and have applied to various state agencies for help, thereby creating a serious financial drain upon the state's exchequer.

A national conference was called by the Federal Security Agency, September 8-10, 1952, at which interested representation from different states and agencies were present. At the conference major discussion centered around the type of committee which should be set up in the states to work on the problem. Committees may be set up in three different ways—by legislative act, by appointment by the Governor, or a voluntary committee. These are citizens' committees and should work with the official agencies who have the legal responsibility in this area.

The function of such a committee would be: (1) gather information and study the problem, (2), make reports, (3) make recommendations, and (4) coordinate the activities of health, education, welfare and other agencies. Practically a unanimous opinion at this conference was that it is not the function of such committees to set up a department to work in this area, but rather to stimulate activity in existing departments.

How functions are carried out:

- (1) Paid staff (Florida)
- (2) Public hearing—annual report—New York City (Legislature)
- (3) Periodic bulletins
- (4) Inter-department committee (California)
- (5) Research projects (in cooperation with University of Florida)
- (6) Lobbying for official committees (Florida)
- (7) Stimulating the formation of local committees.
- (8) More limited service medical agencies
- (9) Organizing groups of older age persons

It was pointed out that proper care of the aged is not just a welfare-health problem, but that all state agencies are concerned.

The Situation as It Exists in Georgia

The percentage increase of older people is out of proportion to the total population. While the total population increase in Georgia from 1940-1950 was 10.3 percent, in the age group 65 and over, the increase was 38.4 percent.

A few years ago the trend was to build institutions for the aged. At the present time, however, community programs have been developed which indicate that the aged do much better in their own home environment. If the aged have to be put in homes, it seems a happier solution to place them near their own home communities. To quote Dr. Robert H. Felix, Director, National Institute of Mental Health, from an article in *The General Federation Clubwoman*, March 1951,

A basic need is the normal desire for a home. This means more than physical shelter. A home is a place that is familiar and secure, adequate for social and recreational activities and, preferably, a center of family life. Too often, perhaps we think of the problem of homes for older people in the form of 'old people's home.' The fact is that only 4 per cent of people over 65 live in such institutions, in nursing homes, or

other residence. The more common problem is that of aging parents left stranded in the old home which is too large and too hard to maintain after the children have married and moved away. Changing to a small apartment at this time may cause emotional strain, yet those who have proper understanding of their real needs usually benefit from a more practical one-way arrangement. This is another facet of our overall problem in mental health. One attempted solution, which has been tried most extensively in Europe, is the construction of special housing for older citizens—small cottages or apartments, convenient to shopping and recreation facilities and designed for ease of access and housekeeping.

Some national effort is being made to see how much the aged are able to be rehabilitated. A great deal of interest is being shown in the problem by the general public, but there is still need for more intensive study of the problem before satisfactory recommendations can be made.

According to a recent appraisal made by the Georgia Department of Public Health, Division of Hospital Services, of the Nursing Home Situation in Georgia, there are approximately 200 institutions in Georgia that provide a variety of domiciliary and medical care for the dependent aged, chronically ill, convalescent, and other unfortunate citizens of the State. Most of these institutions are concentrated in metropolitan areas, but there are a considerable number scattered over the State, some located in isolated places.

Briefly, the following conditions exist to a greater or lesser degree, according to Hospital Services' study, depending upon location and type of service rendered

(1) Most are owned and operated as a private business by untrained personnel.

(2) A significant number do not have a specific name and do not wish to be identified as a nursing home, but rather as a social service agency to the unfortunate or as a boarding home for selected groups of persons.

(3) The amount and type of medical or nursing care rendered in these institutions varies greatly. A few provide medical care to the extent of being classified as general hospitals, as chronic disease hospitals, or as naturopathic hospitals. The majority are operated by registered or practical nurses with a physician subject to call in case of emergency only, or to make periodic calls at the request of the owner. A significant number are operated by individual owners without nursing training or experience or provisions for medical care other than that available to any person. A few are operated as temporary homes for illegitimate mothers, with deliveries made at nearby hospitals.

(4) Included in this problem are the county homes operated by local county officials, employing untrained prison labor to take care of the paupers and indigent disabled, mentally deficient, and aged.

(5) Very few of these homes keep medical records or records of any type on patients. Most of them are located in substandard housing, without

proper facilities. It is a method used by certain individuals with extra large houses to make an income by providing a service that is not readily available for dependent aged.

(6) In a few places, old age colonies are operated in which aged couples are given cottages at a nominal fee with no type of care given except to provide a home and companionship.

(7) Fulton and DeKalb counties license boarding homes and convalescent homes. The City of Atlanta charges a business license ranging in cost from \$18 to \$144 per year, depending on the type of institution and service rendered.

(8) Most of the patients in these nursing homes are welfare cases with old-age assistance checks as the only income from the patients. The Fulton County Welfare Department is beginning to enforce a provision of the Social Security Act which states that "a person who is admitted to a nursing home or private institution as a result of a diagnosis of a mental disease or tuberculosis may not receive public assistance after July 1, 1952." A statement to this effect, signed only by a private physician, has resulted in some financial hardships to individual patients. The purpose of this act is to transfer individuals to public institutions which provide specialized care for this type of disability.

(9) There is urgent need for further study of "nursing homes" problems in this State prior to the inauguration of a program to improve the wide variety of services rendered by these institutions. "Nursing homes" as a classification may or may not include the following institutions, depending on

the type of service rendered:

(1) chronic hospital, (2) convalescent home, (3) nursing home, (4) boarding home, (5) old folks home, (6) county home, and (7) other specialized institutions.

The three types of commissions or committees—legislative, governor appointed, and voluntary—have already been mentioned. Each has its advantages and disadvantages.

If a voluntary committee is set up, it might well be set up as a sub-committee of the Family Life Conference. The Family Life Education Department at the University of Georgia is interested in Geriatrics and has held a state-wide conference at the University. Also, a sub-committee might well be set up under the Better Health Council or the Georgia Association for Mental Health.

Recommendations

It would seem that the most desirable action would be to help set up a voluntary committee, but we do not believe we have sufficiently investigated as to whether this should be in relation to the Family Life Conference, Better Health Council, Mental Health Association, or Citizens Council. A disadvantage of being associated with the Better Health Council or Mental Health Association would be that they function in limited areas.

Within the State Health Department itself, there are several ways in which the problem might be handled: (1) chronic diseases, (2) mental hygiene, (3) jointly by chronic diseases and mental hygiene, and (4) separate program on gerontology be set up in the department.

PRESS COMMENT:

With No Exception

"Like Your Doctor? The question was: 'How do you like your doctors?' The typical reply from some 700 reputed community leaders came back: 'We like our doctors, but our doctors don't seem to like us.' To meet that criticism the American Psychiatric Association and the Association of American Medical Colleges who conducted the survey have recommended more schooling for medical students in human relations." . . . Editorial, The Detroit News, June 16, 1952.

The editorialist, tucking tongue in cheek, then pontificates as follows: "If there is a school that teaches the kind of human relations that makes warm and friendly doctors, we haven't heard about it." And neither have we, nor have we heard of any other school—with no exceptions—that could by any device make anyone either warm or friendly, much less both warm and friendly. No brethren! Such things are the stuff that come as gifts from the gods. We have the essence of them when we come into the world, and it is in our homes that such qualities bloom or wither. The school can only nurture and develop what is brought to it. It can't create. What

the editorialist said about doctors applies as well to workers in any and all fields with no exceptions. We say this not in defense of medical schools or our confreres. We say it as an amen to the editorial's proper indictment of the mores of this the 20th century A.D.

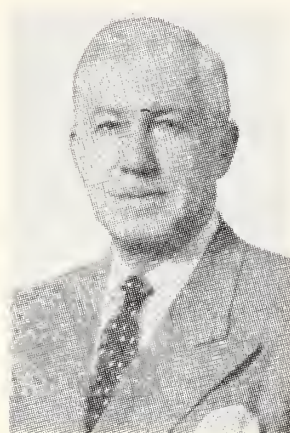
And as a point of information, medical school faculties anticipated the change that would take place in the doctor when medicine passed from the empirical stage, when the doctor had little more than warmth and friendship to offer, to the present highly accurate scientific era. For many years now they have accented human relations in the student's approach to the patient. For example: Each year, a group of Detroit's leading physicians augment the faculty in Sociology, at the College of Liberal Arts of Wayne University, to stress the human side of medicine to premedical students.

With those who come to them with warmth and friendliness as part of their makeup, the medical schools do well. With those barren of such qualities the medical schools do no better or no worse than do other schools.

—DETROIT MEDICAL NEWS

GUEST SPEAKERS

for the MAG 103rd Annual Session, Savannah, May 10-13



Louis H. Bauer, M.D.

Well known to all Association members is the name of LOUIS H. BAUER, M.D., President of the American Medical Association. Dr. Bauer will address the initial meeting of the House of Delegates at the Savannah Annual Session. Dr. Bauer is a graduate of Harvard Medical School and is a diplomate of the American Board of Internal Medicine, and is a Fellow of the American College of Physicians. Dr. Bauer is Chairman of the Board of Trustees of the American Medical Association.



Cyrus C. Sturgis, M.D.

"Some Recent Advances in Hematology" is the subject of the "Calhoun Lecture" address to be presented by CYRUS C. STURGIS, M.D., Professor of Internal Medicine and Chairman of the Department of Internal Medicine at the University of Michigan, Ann Arbor, Michigan. Dr. Sturgis is also the Director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan.

His presentation will entail a brief discussion concerning the indications for and the mode of administration of vitamin B-12, intravenous iron, ACTH and Cortisone, nitrogen mustard, roentgen therapy, urethane, radioactive phosphorus, and blood transfusions in the treatment of various hematological disorders. The disorders will include the management of patients with pernicious anemia, anemia of pregnancy, iron deficiency anemias, leukemia and allied disorders, and polycythemia.

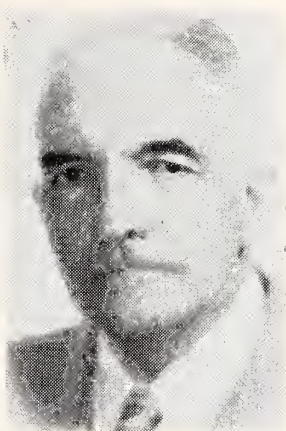


Judge Robert B. Carr

Highlighting the President's Dinner at the Medical Association of Georgia's One Hundred and Third Annual Session will be guest speaker JUDGE ROBERT BRYAN CARR, of Montgomery, Alabama. Judge Carr is the presiding Judge of the Court of Appeals of Alabama.

Receiving his early education in the public schools near his birthplace at Pushmataha, Choctaw County, Alabama, Judge Carr graduated from Southern University, A.B., and from the Law Department, University of Alabama, 1917. He began the practice of his profession in Anniston, was U. S. Commissioner, 1918-20, and in 1924 was elected Presiding Judge of the Seventh Judicial Circuit. He served there until he was appointed to the Court of Appeals of Alabama in 1944. In 1946 he was elected to a six-year term, and at the death of the Presiding Judge, he became Presiding Judge of the Court of Appeals of Alabama. He was without opposition when he successfully was elected to a second term in 1952.

Heyworth N. Sanford, M.D.



Presenting papers on "*Care of the Premature Infant*" and "*Some Problems in the Care of the Newborn*" will be HEYWORTH N. SANFORD, M.D., of Chicago. Dr. Sanford is the Attending Pediatrician Research and Education Hospital and Presbyterian Hospital, Chicago and Chairman of Department at both institutions. He is also the Attending Pediatrician and Head of Department of Pediatric Hematology, Cook County Hospital, Chicago. He was appointed Professor of Pediatrics, University of Illinois in 1945 and has been Acting Head of Department since 1952.

Dr. Sanford was born in Liberty, New York, and graduated from Rush Medical College. He interned at the Presbyterian Hospital, Chicago and served his residency in Pediatrics there. He did post graduate study at the University of Poitiers, France, and in Germany. After serving as Assistant in Pediatrics at Rush Medical College, Chicago, he was appointed Professor of Pediatrics.



Lemuel McGee, M.D.

Speaking on the subject of "*Dysfunction of the Colon*" and "*Operational Responsibilities of a Medical*

Department in Industry" will be LEMUEL McGEE, M.D., Medical Director, Hercules Powder Company, Wilmington Delaware. Other current affiliations of Dr. McGee are: Attending Chief in Medicine, Delaware Hospital, Wilmington; Chief, Clinic in Gastroenterology, Delaware Hospital, Wilmington; President, Medical Board, Delaware Hospital, Wilmington; and Associate in Medicine, Memorial Hospital, Wilmington.

A native of New Boston, Texas, Dr. McGee received his A.B. degree at Baylor University, Waco, Texas; his Ph.D. degree at the University of Chicago (Biochemistry and Physiology); and his M.D. de-

gree at Rush Medical College, University of Chicago. He was the recipient of the E. R. Squibb & Son Fellowship and the National Research Fellowship while at the University of Chicago.

Serving his internship at Baylor University Hospital, Dallas, Texas, and Ralph Brown Medical Service, Presbyterian Hospital, Chicago; Dr. McGee also was a member of the faculty in Physiology and Pharmacology, Baylor University College of Medicine. Dr. McGee was Internist at the Golden Clinic, Davis Memorial Hospital, Elkin, West Virginia. And he was a Research Fellow in Medicine and Biochemistry, Medical School of Harvard University and Peter Bent Brigham Hospital.



Walter H. Sheldon, M.D.

WALTER H. SHELDON, M.D., Chief Pathologist, Emory University Hospital and Professor and Chairman, Department of Pathology, Emory University School of Medicine, Atlanta, will present an address on "*Leptospiral Infection*." Dr. Sheldon is the Chief Pathologist at Grady Memorial Hospital, Atlanta and Consultant Pathologist, U.S.V.A.

Dr. Sheldon was born in Berlin, Germany, and received his M.D. degree at Catania, Italy. He was Assistant Pathologist at the University Pavia, Italy. He served an internship at the Children's Hospital, Boston; was resident in Pathology at Boston Lying-in Hospital and the Free Hospital for Women, Brookline, Mass. Dr. Sheldon was also on the faculty in Pathology at Harvard Medical School and a Research Associate in Pathology at Boston Lying-in Hospital.

JASON P. SANDERS, M.D., of Shreveport, Louisiana, will be featured as a guest speaker at the One Hundred Third Annual Session of the Medical Association of Georgia. Members of the Association are familiar with Dr. Sanders, who recently addressed the Georgia Chapter of the American Academy of General Practitioners and whose talk was printed in the *Journal of The Medical Association of Georgia*, January, 1953. Dr. Sanders is a graduate of University of Texas School of Medicine, Galveston, and is Director of the Sanders Clinic in Shreveport, Louisiana.



Alton Ochsner, M.D.

ALTON OCHSNER, MD., the William Henderson Professor of Surgery and Chairman of the Department of Surgery, School of Medicine, Tulane University of Louisiana, New Orleans, and the Director of the section on General Surgery, Ochsner Clinic and Foundation Hospital, New Orleans, will present two papers at the Annual Session.

The titles of Dr. Ochsner's addresses are "*Acute Cholecystitis*" and "*Early Diagnosis and Treatment of Cancer of the Stomach.*"

At the present time Dr. Ochsner is Senior Visiting Surgeon, Charity Hospital, and Surgeon-in-Chief of the Tulane Surgical Service, Charity Hospital, New Orleans; Senior Surgeon, Touro Infirmary, New Orleans; Consulting Surgeon, Illinois Central Hospital, New Orleans; Consulting Surgeon, Southern Pacific Railroad; Attending Specialist in Chest Surgery, U. S. Public Health Hospital, New Orleans; Consultant in Thoracic Surgery, Veterans Administration Hospital, New Orleans; and Consulting Surgeon, Walton County Hospital, DeFuniak Springs, Florida.

Born in Kimball, South Dakota, Dr. Ochsner graduated from the University of South Dakota, B.A., and Washington University, St. Louis, Mo., M.D. degree. With his internship under Dr. George Dock, Dr. A. J. Ochsner, had a great deal of professional training abroad. Dr. Ochsner also served on the faculties of Northwestern University and Wisconsin.

DUNCAN EARL REID, M.D., of Boston, Mass., will present two talks titled "*Controversial Aspects of Late Pregnancy Bleeding*" and "*Management of the Diabetic Patient in Pregnancy.*" A graduate of Northwestern University Medical School, Dr. Reid has received certification by the American Board of Obstetrics and Gynecology. He is also on the faculty of the Harvard Medical School, Boston, as a Professor of Obstetrics.

LOUIS L. FRIEDMAN, M.D., Director of the Friedman Diagnostic Clinic, Birmingham, Alabama, will present a paper on "*Pneumoconiosis in Soft Coal Workers.*" Dr. Friedman was formerly Instructor in Medicine, Louisiana State University School of Medicine and Assistant Professor of Medicine and Assistant to the Dean, Medical College of Alabama.

Dr. Friedman was a graduate of the University of Arkansas School of Medicine, Little Rock, Arkansas, 1941.

Presenting papers on the subjects of "*What to Expect of the Photofluorogram*" and "*Diabetes and Tuberculosis*" is SYDNEY JACOBS, M.D., of New Orleans. Dr. Jacobs graduated from Tulane University of Louisiana School of Medicine, New Orleans. He has been certified by the American Board of Internal Medicine and is a Fellow of the American College of Chest Physicians, American College of Physicians and the American Trudeau Society.

Dr. Jacobs is on the faculty of the Tulane University of Louisiana School of Medicine in the Department of Clinical Medicine.



Robert D. Moreton, M.D.

Addresses on "*Gastrointestinal Bleeding*" and "*Barium Enema Study of the Large Intestine*" will be

presented by ROBERT D. MORETON, M.D., of Fort Worth, Texas. Dr. Moreton, a graduate of University of Tennessee College of Medicine, Memphis, is certified by the American Board of Radiology. He is a Fellow of the American Roentgen Ray Society, Radiological Society of North America, Inc., and the American College of Radiology.

Military Data . . .

Twelve physicians were inducted into the Armed Forces as enlisted men between passages of Public Law 779 in June 1950 and December 1, 1952. While the Secretary of Defense requested Selective

Service to call 2,234 physicians during this period, of the numbers called for induction all accepted Reserve Commissions before the dates they were ordered for induction, except the 12 physicians.

First Annual Presidents and Secretaries of District and County Medical Societies Conference

With over 120 members of the Medical Association of Georgia attending the first annual "Presidents and Secretaries of all District and County Medical Societies Conference" held in Atlanta, February 22, the groundwork was laid for (1) closer liaison between the Association and its component societies, (2) better understanding of the organization and function of societies on the district and county level, (3) better grasp of the problems confronting the district and county societies and (4) orientation on Medical-Military policies.

Beginning the program, Mr. Sid Wrightsman, Jr., MAG Executive Secretary, explained the activities of the state organization office. After a detailed description of the Association and its service to the component societies comprising the organization, Mr. Wrightsman indicated many ways in which the MAG could further aid the society membership.

Mrs. Ralph Fowler, MAG Auxiliary President, gave an address on the Woman's Auxiliary and told of the aims and objectives of the Auxiliary. Citing many of the projects of the Auxiliary, Mrs. Fowler explained the accomplishments and potentialities of her organization.

From the AMA Council on Medical Services, Mr. Thomas Hendricks gave a clear picture of the duties of the county society. His talk on "What Is Your County Society H.Q.?" described in detail the benefits gained from an effective County society.

Assistant Director of the AMA Washington Office, Dr. C. H. Maxwell addressed the conference on the topic "Your Stake in the 83rd Congress." His talk covered the existing problems and proposed legislation currently before the 83rd Congress in the medical field. Dr. Maxwell covered the activities of his office and ways and means of support in aiding or halting national legislation that affects the medical profession.

The controversial film, "Without Fear" was shown the conference and it raised a great deal of comment. This film, produced by the AF of L Machinist Union, for public consumption presents an extremely bias and often inaccurate picture of the health problems facing the nation. The film, of course, suggests with emphasis that national health insurance is the easy, simple remedy to *all* the medical problems of today and tomorrow. This film was followed by the short documentary film, "Your Doctor" which tells the story of service to the citizen performed by the medical profession. The film will be shown in Georgia at

many local theaters during the month of March in celebration of the March 30 observance of Doctor's Day.

Members of the Association and their wives were guests of the Association for a luncheon served in the Academy of Medicine.

The District Advisory Subcommittees on Selective Service met following the luncheon. Discussion of the problems and program of Selective Service as it affects the doctor, was lead by a panel of experts. Dr. Maxwell described the national picture and discussed the new *proposed* Doctor-Draft law with its new changes of (1) reversing priority two and three; (2) scale of rank for commissions depending upon years in practice; (3) lowering of physical standards to include doctors in regular practice; (4) policy at the present time of calling doctors in priority three up to the age of 35; and (5) the slow and steady increase of VA medical care which further encroaches on the private practice of medicine. Major William Hatcher, Adjutant General Corps, and Lt. Col. Mike Y. Hendrix, Artillery Corp, both of the State Headquarters Selective Service System, gave details of the local situation. Questions from the conference were answered and committee activities were discussed.

Finishing the day's program were the panel discussions on "Function of the District Society" and "Organization of the County Society" which were combined into one large panel with Dr. William P. Harbin, Jr. presiding and Dr. Charles H. Richardson, Jr. moderating. The panel discussed the many viewpoints of District and County Society organization and function. Questions and opinions from the audience were brought into the panel discussion.

The conference was adjourned at 4:30 p. m. Presidents and Secretaries of District and County Societies attending the Conference are listed below by District and County Society.

FIRST DISTRICT

Samuel F. Rosen, President
Wm. H. Fulmer, Secretary

BULLOCH-CANDLER-EVANS

Albert M. Deal, Secretary

SECOND DISTRICT

Frank A. Little, Secretary

THIRD DISTRICT

John H. Robinson, President

MUSCOGEE

C. W. Henderson, President

RANDOLPH-TERRELL

John A. Ward, President
Robert B. Martin, Secretary

FOURTH DISTRICT

George P. Kinnard, Secretary

NEWTON

Clarence B. Palmer, Secretary

UPSON

John D. Blackburn, President
W. J. Gower, Secretary

DEKALB

W. A. Mendenhall, President

FULTON

W. G. Hamm, President

SIXTH DISTRICT

William Rawlings, President
C. H. Richardson, Jr., Secretary

BIBB

Henry H. Tift, Secretary

JASPER

E. M. Lancaster, Secretary

MONROE

George H. Alexander, Secretary

CARROLL-DOUGLAS-HARALSON

D. S. Reese, Secretary

COBB

C. M. Garland, Jr., President

FLOYD

Stephen D. Smith, Secretary

WALKER-CATOOSA-DADE

E. M. Townsend, Secretary

EIGHTH DISTRICT

Sage Harper, Secretary

COFFEE

Sage Harper, Secretary

SOUTH GEORGIA MEDICAL SOCIETY

A. G. Little, Secretary

WARE

T. J. Ferrell, Secretary

HABERSHAM

L. G. Hicks, Jr., Secretary
C. M. Henry, President

HALL

W. B. Nalley, President

STEPHENS

C. L. Ayers, Secretary

TENTH DISTRICT

A. W. Simpson, President
Bothwell Traylor, Secretary

CLARKE

J. A. Green, President
John D. Elder, Secretary

FRANKLIN

Stewart D. Brown, Jr., President

McDUFFIE

A. G. LeRoy, Secretary

RICHMOND

W. K. Philoot, President

Members of the District Advisory Subcommittees on Selective Service who attended the 1:30 p. m.

Selective Service discussion meeting are listed below by district.

FIRST DISTRICT ADVISORY SUBCOMMITTEE

Albert M. Deal, M.D., Statesboro
Oscar H. Lott, M.D., Savannah
D. B. Fillingim, M.D., Savannah
William H. Fulmer, M.D., Savannah
David Robinson, M.D., Savannah
John Mooney, Jr., Statesboro
J. C. Metts, M.D., Savannah

SECOND DISTRICT ADVISORY SUBCOMMITTEE

Howard L. Cheshire, M.D., Thomasville
Kirk Shepard, M.D., Thomasville
M. W. Williams, M.D., Camilla

THIRD DISTRICT ADVISORY SUBCOMMITTEE

L. H. Wolff, M.D., Columbus
Roy L. Gibson, M.D., Columbus
P. C. Graffagnino, M.D., Columbus
R. B. Martin, M.D., Columbus
R. B. Martin, M.D., Cuthbert

FOURTH DISTRICT ADVISORY SUBCOMMITTEE

J. H. Arnold, M.D., Newnan
George P. Kinnard, M.D., Newnan
Virgil Williams, M.D., Griffin
W. R. King, Jr., M.D., Griffin
J. W. Chambers, M.D., LaGrange
J. S. Holder, M.D., LaGrange
D. L. Head, Jr., M.D., Thomason

FIFTH DISTRICT ADVISORY SUBCOMMITTEE

H. H. Allen, M.D., Decatur
Darrell Ayer, M.D., Atlanta
E. D. Shanks, Jr., M.D., Atlanta
Edgar M. Dunstan, M.D., Atlanta
Robert W. Candler, M.D., Atlanta
James H. Semans, M.D., Atlanta

SIXTH DISTRICT ADVISORY SUBCOMMITTEE

E. Y. Walker, M.D., Milledgeville
Henry H. Tift, M.D., Macon
L. D. Porch, M.D., Macon
Frank Vinson, M.D., Fort Valley
J. A. Bell, Jr., M.D., Dublin
George H. Alexander, M.D., Forsyth

SEVENTH DISTRICT ADVISORY SUBCOMMITTEE

Wm. B. Qiullian, Jr., M.D., Cartersville
Alfred Colquitt, Jr., M.D., Marietta
Lester Harbin, M.D., Rome
John McCall, Jr., M.D., Rome
John McGehee, M.D., Cedartown
D. L. Wood, M.D., Dalton

EIGHTH DISTRICT ADVISORY SUBCOMMITTEE

Sage Harper, M.D., Douglas
H. L. Moore, M.D., Brunswick
A. G. Little, M.D., Valdosta
B. G. Owens, M.D., Valdosta
T. J. Ferrell, M.D., Waycross
B. E. Collins, M.D., Waycross
J. W. Yeomans, M.D., Jesup

NINTH DISTRICT ADVISORY SUBCOMMITTEE

Joe J. Arrendale, M.D., Cornelia
W. B. Nalley, M.D., Helen
E. W. Grove, M.D., Gainesville
John M. Hulsey, M.D., Gainesville
Alex B. Russell, M.D., Winder
Bruce Schaefer, M.D., Toccoa

TENTH DISTRICT ADVISORY SUBCOMMITTEE

S. B. Traylor, M.D., Athens
J. H. Milford, M.D., Hartwell
Albert G. LeRoy, M.D., Thomson
T. W. Middlebrooks, M.D., Union Point
Lynn Huie, M.D., Monroe.

Report of MAG COUNCIL

Executive Committee Meeting, February 22, 1953

The Council Executive Committee . . . comprised of Drs. W. Bruce Schaefer, C. F. Holton, David Henry Poer and J. W. Chambers (in absence of Chairman H. Dawson Allen) . . . met in regular session in Atlanta at 9:30 a. m.

The following action was taken:

1. *Authorized* travel expense, not to exceed \$150 each for both AMA Delegates Eustace A. Allen of Atlanta and Charles H. Richardson, Sr. of Macon for attendance at the special called meeting of the AMA House of Delegates, Washington, D. C., March 14, 1953.

2. *Designated* Dr. J. W. Chambers as Georgia representative at the National Health Council convention, New York City, March 17-18, at request of AMA Secretary George Lull, his travel expense to be assumed by the Medical Association of Georgia.

3. *Approved* policies to date carried out by the Association headquarters office in regard to the 1953 Annual Session.

4. *Recommended* increased activity by and greater cooperation with the Association headquarters office on the part of the Committee on Legislation during future meetings of the Georgia Legislature.

The meeting adjourned at 10:05 a. m.

CONSTITUTION *and* BY-LAWS

Committee Meeting, January 11, 1953

At a meeting of the Constitution and By-Laws Committee held at the Academy of Medicine, Atlanta, January 11, 1953, the following members were present: Dr. Allen H. Bunce, Atlanta; Dr. David Henry Poer, Atlanta; Dr. W. F. Reavis, Waycross; Dr. Enoch Callaway, LaGrange; and Dr. James H. Seamans, Atlanta.

The Committee discussed in detail proposed amendments to the existing Constitution and By-Laws of The Medical Association of Georgia. The following proposed changes were recommended by the Committee.

(In each of the quoted passages that follow, a word or phrase within brackets indicates a deletion from the existing text; while an italicized word or phrase, an addition to the present phraseology, as recommended by Committee. An asterisk indicates a minority report.)

Proposed Amendments to the Constitution

Article VIII. District Societies

"In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts which [shall be co-extensive] *may be coextensive* with the

Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies."

Article IX. Officers

"Section 1. Officers. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor [from each of the Councilor District Societies] *and a Vice-Councilor from each of the Councilor District Societies* as provided in the By-Laws."

*Article XIV. Association Headquarters

The headquarters of the Association shall remain in Atlanta unless changed by a vote of the members of the Association.

Proposed Amendments to the By-Laws

Chapter I. Membership

"Section 5. Associate Members. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during *temporary* periods of service in the Armed Forces, (3) . . ."

"Section 7. Life Members. A Life membership may be granted by the House of Delegates, upon recommendation of the component county society,

to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. * [He shall not be subject to payment of dues.] *He may be excused from payment of dues.*"

"Section 8. Scientific Members. Any negro physician meeting qualifications as set forth in Section 1 may be granted scientific membership by the component county society, upon application, and be awarded the privileges of participation in all scientific sessions. Such members shall pay no dues to the county society or State Association, [but may be subject to payment of all dues and assessments of the American Medical Association.] . . ."

Chapter III. House of Delegates

"Section 2. Each component society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by [March 1st of each year] *December 31st of the preceding year*, provided that each component society shall be entitled to at least one delegate. . . ."

"Section 4. The House of Delegates shall be presided over by a Speaker, or a Speaker pro tem, whose election shall be the first order of business at the [opening] *final session and who shall serve until his successor is elected and installed.*"

"Section 5. The Secretary-Treasurer of the Association shall be the secretary of the House of Delegates or, in his absence, [by a delegate appointed] *a delegate may be appointed by the President. The Executive-Secretary may serve in this capacity.*"

"Section 6. The following shall be the general Order of Business at [all] *the meetings of the House of Delegates*: 1. Call to order by the President; 2. Roll Call; [3. Election of Speaker and Speaker pro tem;] [4.] 3. Reading and adoption of minutes; [5.] 4. Reports of officers; [6.] 5. Reports of Committees; [7.] 6. Unfinished business; [8.] 7. New Business."

"Section 7. For the purpose of expediting proceedings the [President] *Speaker* shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary."

Chapter V. Election of Officers

"Section 5. Delegates and Alternates to the American Medical Association shall be [elected in the same manner and at the same time and] *chosen by the House of Delegates* in accordance with the Constitution and By-Laws of the American Medical Association."

Chapter VI. Duties of Officers

"Section 4. The Secretary-Treasurer. (a) The Secretary-Treasurer *or his representative* shall attend the general meetings of the Association and . . ."

Chapter VII. Component County Societies and District Societies

"Section 2. Charter. . . . *When membership in a county society falls below the minimum of three members, the charter of such society shall be forfeited automatically. The remaining members shall be classified as members-at-large, and shall lose none*

of their benefits and privileges of active membership."

"Section 10. Annual Meeting. Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on [Public Policy and] Legislation and . . ."

"Section 11. Purposes and Duties of the District Societies. . . . At the same time, each shall elect a member to the sub-committee on [Public Policy and] Legislation and Public Health of the Association."

Chapter VIII. Dues and Assessments

"Section 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on [or before] January 1st of the year for which they are levied. . . . At no time and under no circumstances shall a member, *except members-at-large*, make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association, *except from a member-at-large*, receive payment of dues or assessments from anyone except the secretary of the component county society or his representative. *Any active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears, subject to the approval of his county society and provided he reapplies for membership and acceptance to his county society, and also subject to approval by Council.*"

Chapter IX. Standing Committees

"Section 1. The Standing Committees of the Association shall be as follows:

- (a) Committee on *[Scientific Work] *Sessions*
- (c) Committee on Medical Education *[and Hospitals]
- (e) *[Committee on Professional Conduct] *Committee on Hospitals and Institutions*
- (m) *[Committee on] *Insurance Board*
- *(n) *Committee on Veterans Affairs*
- *(o) *Board of Governors*"

"Section 2. . . . Provided that for the first year the President shall appoint three or more members [are] *as required*, with one member to serve for the necessary graduated period of years to meet these requirements. . . ."

"Section 3. The Committee on *[scientific Work] *Sessions*. The Committee on *[Scientific Work] *Sessions* shall be composed of five members: . . . The duties of the Committee on *[Scientific Work] *Sessions* shall be to prepare and publish . . . These special lectures shall be given before the general meetings at a time selected by the Committee on *[Scientific Work] *Sessions.*"

"Section 5. The Committee on Medical Education *[and Hospitals]. The Committee on Medical Education *[and Hospitals] shall consider and devise . . . *[It shall pursue a continuing study of the

relation of the medical profession to the operation of public and voluntary hospitals within this State, and shall, when indicated confer with the State Department of Health, the Georgia State Hospital Association, and all related organizations and make recommendations to the Association.]

"Section 7. * [The Committee on Professional Conduct. The Committee on Professional Conduct shall . . .] (deleting all of Section 7) . . . *The Committee on Hospitals and Institutions. The Committee on Hospitals and Institutions shall be composed of ten members, representing each Councilor District. The members shall be appointed by the President for the following terms: two members, five years; two members, four years; two members, three years; two members, two years; and two members, one year. The president will annually appoint two members to fill expired terms. The duties of this committee are to pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State, and shall when indicated confer with the State Department of Health, the Georgia Hospital Association, and all related organizations and make recommendations to the Association.*"

"Section 12. . . . * [The Director of the Industrial Hygiene Division of the State Department of Public Health shall be a member ex officio.] *Should consultation with the Department of Public Health be necessary, requests for same shall be forwarded to the State Director of this department. . . .*"

"Section 15. The * [Committee on Insurance or] Insurance Board shall consist of not less than five members appointed for a period of five years [in rotation] by the President. . . ."

*Section 16. *Committee on Veterans Affairs. The Committee on Veterans Affairs shall be composed of ten members, representing each Councilor District. The members shall be appointed by the President for the following terms: two members, five years; two members, four years; two members three years, two members, two years; and two members, one year. The President will annually appoint two members to fill expired terms. The duties of this committee shall be to investigate, analyze and make recommendations on all matters concerning the profession and veterans of World Wars, Korea, etc.*

*Section 17. *Board of Governors. The Board of Governors shall consist of the five most recent past presidents of the Association with appointment by the President to fill any vacancy. The senior member shall be chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigation of a member, shall become the concern of the Board. Complaints may be made by an individual*



patient, physician, board of censors of any local medical society, attorney or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Board, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Board is convinced there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Board to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged at such hearing. No member of this Board shall sit in a hearing involving a physician from his Councilor District.

After deliberation the Board shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.

2. Attempt a satisfactory adjudication of the complaint.

3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.

4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

The Board of Governors shall study the plans and policies of and for the Association, meeting at least once annually sixty days prior to the Annual Session for such purpose and shall report in writing to the House of Delegates at each Annual Session their findings and recommendations.

The Board of Governors shall also act in an advisory capacity to the Woman's Auxiliary.

* [Chapter X. Special Committees]

* [1. Woman's Auxiliary.]

ANNOUNCEMENTS

MARCH 18: First District Medical Society will hold their meeting in Statesboro.

MARCH 25: Jefferson County Medical Society will meet at the Jefferson Hotel, Louisville, Ga., at 8:00 p. m.

APRIL 1: Seventh District Medical Society will meet at Rome, Ga.

APRIL 2: Second District Medical Society will meet in Albany at 3:00 p. m. at the American Legion Clubhouse.

APRIL 3: Fulton County Medical Society will meet at the Academy of Medicine, Atlanta, 6:30 p. m. dinner; 7:30 p. m. scientific program.

APRIL 7: Spalding County Medical Society will hold their monthly meeting at the Spalding County Hospital.

APRIL 14: Eighth District Medical Society will meet at Valdosta.

APRIL 16: Habersham County Medical Society will hold their monthly meeting.

APRIL 17-18: Southern Society of Anesthesiologists will meet at the Academy of Medicine, Atlanta, with Headquarters at the Biltmore Hotel, Atlanta.

MAY 7-8-9: American Goiter Association will meet in the Drake Hotel, Chicago, Illinois. The program for the three day meeting will consist of papers and discussions dealing with goiter and other diseases of the thyroid gland.

MAY 15-16: The Southeastern Allergy Association will meet at the Andrew Jackson Hotel, Nashville, Tenn. For further information write: Dr. Katherine Baylis MacInnis, Secretary, 1515 Bull St., Columbia, S. C.

SOCIETIES

Bibb County Medical Society inaugurated the Annual Witman Lectureship at their last meeting February 27. The guest speaker was Dr. Samuel Prodder, of Boston, who presented a paper on "The Cardiac Patient as a Surgical Risk."

Cherokee-Pickens County Medical Society, at their January 30 meeting elected officers for 1953-54. New officers elected were: President—Dr. Arthur Hendrix, of Canton; Vice President—Dr. Ben K. Looper, of Canton; Secretary Treasurer—Dr. William Nichols, of Canton. Elected as Delegate was Dr. T. C. Boswell, of Tate, and Dr. C. J. Roper of Jasper was named Alternate.

Emanuel County Medical Society elected Dr. Randall G. Brown, of Garfield, president of the society. Dr. C. E. Powell, of Swainsboro, was named vice president and treasurer.

Georgia Medical Society heard Dr. Duncan Shepard, of Atlanta, present a paper on "Residual Common Duct Stones" at their regular monthly meeting February 10.

Glynn County Medical Society, at their January meeting, elected Dr. L. G. Towson, of Sea Island,

president of the society for 1953. Dr. Haywood L. Moore, of Brunswick, was elected vice president and Dr. J. M. Hicks, of Brunswick was named secretary treasurer.

Habersham County Medical Society met February 12 in a combined meeting with the Medical Auxiliary for dinner, followed by separate business meetings at the Commercial Hotel, Cornelia. Dr. C. W. Whitworth, of Gainesville was the guest speaker and spoke on the subject "Conditions and Treatment of the Nose and Sinuses." Beginning in March, regular meetings will be held on the *third Thursday* of each month at 7:30 p. m.

Walker-Catoosa-Dade County Medical Society installed at their last meeting Dr. Thomas W. Alsobrook, of Rossville, as president for 1953. Also elected were Dr. T. N. Cochran, of Ringgold, president-elect; and Dr. E. M. Townsend, of Ringgold, secretary treasurer.

Walton County Medical Association, at their annual organizational meeting elected the following officers: President—Dr. S. J. DeFreese, of Monroe; Vice President—Dr. Harry B. Nunnally, of Monroe; Secretary—Dr. Ernest Thompson, of Monroe; and Alternate Delegate—Dr. P. R. Stewart, also of Monroe.

DEATHS

LANIER: Dr. John Edward Lanier, 80, pioneer Colquitt county physician, died January 25 after an illness of two weeks. Dr. Lanier, who practiced med-

icine in Colquitt county for 50 years, was a graduate of Medical College of Georgia, 1900. A native of Bulloch county, Dr. Lanier practiced medicine in Norman Park for three years before moving to Moultrie, where he had been active in the medical field until just a short time before his death.

RIDLEY: *Dr. Frank M. Ridley, Jr.*, 69, of LaGrange, died January 29 in the City-County Hospital after a two-week illness. Dr. Ridley practiced medicine in LaGrange for 47 years and served for a number of years as a member of the Board of Medical Examiners of Georgia. He graduated from the Atlanta College of Physicians and Surgeons in 1906.

ROWE: *Homer L. Rowe*, 69, of Social Circle, who was the first executive secretary of the Medical

Association of Georgia, died February 7 at Social Circle. Mr. Rowe was educated in Carroll county public schools and attended business college in Atlanta. He was employed as executive secretary of the Association February 1, 1926 and continued in that capacity until October 1, 1944 when he resigned. He also was business manager for the Association during those years.

SHANKS: *Edgar DeWitt Shanks*, 63, of Atlanta. See *Editorial* for biographical sketch.

PERSONALS

Dr. John M. Anderson, Atlanta, announces the opening of his office 15 Peachtree Place, N. W., Atlanta. Dr. Anderson is a Diplomate of the American Board of Psychiatry and Neurology.

Dr. Alfred Agrin, Atlanta, announces the opening of offices for the practice of child psychiatry at 1447 Peachtree Street, N. E., Atlanta. Dr. Agrin is a graduate of Johns Hopkins University and Tufts College Medical School. He is certified by the American Board of Psychiatry and Neurology.

Dr. Lewis H. McDonald, Atlanta, and *Dr. Irvin Blumenthal*, Atlanta, have recently been certified by the American Board of Surgery.

Dr. James A. Bussel, of Abbeville, was recently honored in an editorial in the *Abbeville Chronicle* written in celebration of his eightieth birthday.

Dr. G. H. Folsom, Lakeland, received a bronze plaque and a special citation in tribute of his quarter of a century of service to his community by the Lakeland W.O.W. Camp in a ceremony held in Lakeland February 1.

Dr. John A. Duncan, formerly of Cordele, has moved to Harlem to occupy the office of the late Dr. J. G. Saggus.

Dr. William G. Hamm, *Dr. Frank K. Kanthak* and *Dr. Charles P. Yarn, Jr.*, announce the removal of their offices to Suite 206, 710 Peachtree St., N. E., Atlanta, for the practice of plastic and reconstructive surgery.

Dr. Harry Morse, recently on the staff of the U. S. Naval Hospital, Bethesda, Md., and Diplomate of the American Board of Otolaryngology, announces his association with the Ponce de Leon Eye and Ear Infirmary.

Dr. D. Frank Mullins, Jr., formerly of Athens, has recently accepted appointment to the faculty of the Medical College of Georgia as Association Pro-

fessor of Pathology, Associate Pathologist to the University Hospital and member of the Consultant Staff, Veterans Hospital, Augusta.

Dr. Jack Norris, Atlanta, recently addressed the Atlanta Woman's Club on the topic "American Responsibility, the United Nations, and World Peace."

Dr. David Henry Poer, Atlanta, has been appointed to the Advisory Committee of the American Medical Writers' Association for 1953. Dr. Poer is Editor of the *Journal*.

Dr. Joseph L. Rankin, Atlanta, announces the removal of his office to Suite 712, Medical Arts Building, Atlanta, for a practice limited to dermatology.

Dr. Robert A. Sears is now associated with The Neuroclinic in the Doctors Building, Atlanta.

Dr. Walter H. Thiele, of Fayetteville, N. C., has been appointed manager of the VA Hospital in Atlanta. Dr. Thiele, formerly chief of professional services at the VA Hospital, Fayetteville, succeeds *Dr. Horace B. Cupp*, of Atlanta. Dr. Cupp was appointed manager of the new VA Hospital at Durham, N. C.

Dr. Peter B. Wright, of Augusta, and the former Mrs. Elizabeth Lee, of Augusta, were married on January 9. Following a trip to Bermuda, the couple vacationed in Chicago, where Dr. Wright attended the annual meeting of the American Academy of Orthopedic Surgeons, January 24-29. Dr. Wright also attended a Seminar on the Rehabilitation of Crippled Children held at the Physical Medicine Institute, New York University, on the New York leg of their trip.

Drs. Woodrow W. Lovell and *William Bondurant*, of Atlanta, were also in attendance at the Seminar on the Rehabilitation of Crippled Children at the Physical Medicine Institute, New York University.

Lieutenant (jg) Eugene M. Flowers, of Tifton, has reported to the U. S. Naval Air Station in Jacksonville, Fla., for two weeks training (active reserve duty) with the Malaria and Mosquito Control Unit.

HOSPITALS

Elected to serve for varying terms on the Board of Trustees of Georgia Hospital Service Association, Inc., at its annual meeting held in January were the following doctors: Dr. W. G. Chambless, of Hamilton; Dr. R. A. Collins, of Montezuma; Dr. R. L. Kennedy, of Metter; Dr. J. P. Tucker of Bainbridge; and Dr. Woodrow Goss, of Ashburn.

Dr. G. M. White, of Rockmart, was named chief of staff at the new Rockmart-Aragon hospital in Rockmart. This hospital was dedicated in January and currently has seven physicians on its staff.

Emory University Clinic, organized January 1, by a group of doctors who are faculty members in the School of Medicine, is a partnership arrangement by this group of physicians who will teach medical students and carry on research in the medical sciences while continuing their private practice. The partnership, by an agreement with the School of Medicine, provides its doctor-teacher members with time and tools to work in this way.

The Clinic now numbers about 20 members, all of whom are also members of the medical faculty of the University. Ultimately, some 50 or 60 doctors will belong to the group. Their offices will be in or near the Emory Hospital. While the Clinic doctors have agreed that faculty membership be prerequisite to Clinic membership, the relationship between the physician and the patient remains a personal one.

AUXILIARY

Baldwin County Medical Society Auxiliary met in Macon January 13, in joint session with *Bibb County Medical Society Auxiliary* at the Sidney Lanier Cottage. Mrs. Edgar Dunstan, of Atlanta, Chairman of Civil Defense auxiliary activity spoke on the subject of the Statewide Civil Defense plan. Mrs. Shelly Davis, of Atlanta, co-chairman of the committee also addressed the auxiliary.

Bibb County Medical Society Auxiliary sponsored the annual Health Education meeting in Macon February 10. Headlining the day's program was Dr. Amey Chappell, of Atlanta, who discussed physical problems of women. Dr. Chappell practices obstetrics and internal medicine and is on the medical faculty at Emory University School of Medicine.

Fulton County Medical Society Auxiliary has recently sponsored a Tea and Fashion Show for the Nurses Education Fund held at Druid Hills Golf

Club January 28. At their February 4 meeting Miss Thelma Thompson reviewed her latest book "Make Haste. My Beloved." The meeting was in honor of the wives of members of the legislature and Governor's staff.

Georgia Medical Society Auxiliary, at their January 9 meeting at the Savannah Golf Club, heard Mrs. Ralph Fowler, state president of the Auxiliary. Mrs. Fowler was the guest speaker on the program.

Ware County Medical Society Auxiliary met January 8 at the Episcopal Parish House in Waycross. Dr. Arthur M. Knight, Jr., guest speaker for the occasion, spoke on the topic of mental hygiene. The next meeting will be in March.

Whitfield Medical Society Auxiliary elected Mrs. Hubert King, of Dalton, president of their organization at a meeting held at the Elks Club, Dalton, on January 7. Other officers elected were Mrs. Lloyd Yeargin, vice-president; Mrs. Albert Boozer, secretary-treasurer; and Mrs. E. A. Rosen, publicity chairman.

Geriatrics Lectures

Dr. Edward J. Stieglitz of Washington, D. C., early next spring will give a series of lectures at the Milledgeville State Hospital Auditorium. Dr. Stieglitz is one of the foremost pioneers in the field of geriatrics and a most delightful and interesting speaker.

On Friday, April 10, 1953, at 8 p. m., Dr. Stieglitz will talk on the subject of "The Challenge of Longevity" wherein the sociologic aspects will be

stressed. At 3 p. m., on Saturday, April 11, 1953, he will have as his subject, "The Aging Person" which will be concerned primarily with the mechanisms and consequences of so-called "normal" senescence. At 8 p. m. on Saturday, April 11th, his subject will be "Anticipatory Psychiatry in Maturity", concerned with the predictable emotional traumata of senescence and the prevention of undue stress.

JOURNAL of The Medical Association of Georgia

APRIL • 1953

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Annual Session Issue

unusually effective in infections
of the gastrointestinal tract



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in typhoid fever and is considered by many
to be useful in other salmonellosis

outstanding in acute Shigella dysentery, CHLOROMYCETIN permits immediate treatment regardless of dehydration and provides rapid relief.

exceptionally well tolerated, CHLOROMYCETIN (chloramphenicol, Parke-Davis) is noted for the infrequent occurrence of even mild gastrointestinal side effects, an important consideration in treating infections of the gastrointestinal tract. Although serious blood disorders following its use are rare, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections — and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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The JOURNAL

of the

MEDICAL

ASSOCIATION

OF GEORGIA

APRIL, 1953

VOLUME 42 NUMBER 4



Photo by Carolyn Carter

With less than a month before the One Hundred and Third Annual Session of the Medical Association of Georgia, this issue of the *Journal* is devoted to giving you an overall picture of the MAG event of the year.

Savannah, the host city for the Annual Session, is represented fittingly by the charming grace of the "iron lacework" that is the hallmark of Old Savannah, as portrayed by the cover picture.

And with this Annual Session Issue of the J MAG goes our recommendation for you to attend—a great meeting has been planned—and your being there will help make it the biggest and best Annual Session yet. The slogan for this issue is "See You in Savannah."

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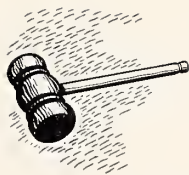
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DR. C. F. HOLTON
MAG President



President's Page

gen", by Bates Block, Atlanta; "Salvarsan in the Treatment of Syphilis and Para Syphilis of the Nervous System", by James N. Brawner, Atlanta; "Paramyoclonus Multiplex", by Thomas S. Clay, Savannah; and "Treatment of Pneumonia", by J. W. Palmer, Ailey; "Most Prevalent Intestinal Parasites Found in Georgia", by A. G. Fort, Atlanta; "Cardio Renal Vascular Diseases", by Stewart R. Roberts, Atlanta; "Syphilis from the Standpoint of the Physician", by Cosby Swanson, Atlanta; "Eclampsia", by H. W. Birdsong, Ashland; "Report of a Few Cases of Transfusion", by C. C. Harrold, Macon; "Puerperal Infection, Its Cause and Treatment", by J. D. Chason, Bainbridge; "Cancer Uteri", by E. C. Cartledge,

FORTY YEARS AGO

As we grow older one of the few privileges left is to reminisce.

When, on May 13, 1953, I place my gavel in the capable hands of Dr. William Harbin of Rome, it will mark to the day exactly 40 years since I stood in line with class of '13 to receive my diploma as a Doctor of Medicine.

Unfortunately, many of those bright young lads who stood beside me on that day in May have been called to their eternal reward. Notably among those missing today are Bill Roberts, Bill Lake, Blake Armstrong, Henry Grady Carter, Rex Barfield, Jake Sauls, Jim Pittman, Ed Shanks, and many, many others who lived and practiced with the high ideals of good doctors. To them an affectionate salutation.

On May 10, 1953, the 103rd Annual Session of the Medical Association of Georgia convenes in Savannah. By another coincidence, the meeting 40 years ago also was held in Savannah. Let's take a look and see what our friends were interested in at that time.

For the first time in the history of the Association, it was decided to split the meeting into two sections—medical and surgical. We had growing pains even at that long distant date. There were 95 papers on the program, all by Georgia doctors. Among the subjects under discussion were the following: "Sterilization of Confirmed Criminals, Idiots and Rapists", by W. L. Champion, Atlanta. Too bad they didn't go ahead with that idea. "Rabies, Pasteur Treatment of", by C. D. Greer of Atlanta (now of Brunswick); "Treatment of Chorea with Rheumatism Phylaco-

Atlanta; "The Alimentary Tract, the Portal of Entrance to Tubercle Bacilli", by E. C. Thrash, Atlanta; "Sodium Cacodylate in the Treatment of Malaria", by E. E. Murphey, Augusta; "Haematuria", by W. B. Crawford, Savannah; "Haemoglobinuric Fever", by L. B. Royal, Girard; "A Better Way of Putting a Diaper on a Baby", by S. A. Visanska, Atlanta; "Intubation in Diphtheria", by W. N. Adkins, Atlanta; "The Clinical Significance of the Infant's Stool", by Herman W. Hesse, Savannah; "The Treatment of Trachoma from a Surgical Standpoint", by St. J. R. deCaradeuc, Savannah; "Cholera Infantum", by S. A. V. Christophine, Attapulugus; "Optic Atrophy Caused by Uterine Hemorrhage", by F. P. Calhoun, Atlanta; "Raynauds Disease", by Lawrence Lee, Savannah; "The Offending Tonsil", by W. C. Lyle, Augusta; "Tumors of the Carotid Body", by John Funke, Atlanta; "The Interpretation of the Wasserman Reaction", by E. G. Ballenger, Atlanta; "Is Floating Kidney a Surgical Disease", by Wm. Perrin Nicholson, Atlanta; "Prostatitis", by Montague Boyd, Atlanta; "Acute Osteo Myelitis", by F. K. Boland, Atlanta; "The Care of the Eyes of Children While Employed Indoors", by Hugh M. Lokey, Atlanta; "Post Operative Hemorrhage and Surgical Shock", by W. W. Battey, Jr., Augusta; "Treatment of Typhoid Hemorrhage", by Thomas D. Coleman, Augusta; "Caesarian Section With Report of Case", by S. T. Barnett, Atlanta; "Stock Vaccines vs. Auto-genous Vaccines", by C. W. Gould, Atlanta; "A Review of Three Thousand Cases of Fever Under the Salicylate of Soda Treatment", by B. P. Oliversons, Savannah; "Practical Anesthesia", by Chas. Usher, Savannah; "The Use of Medicine Hypodermically",

by C. M. Curtis, College Park; "Local Anaesthesia With Special Reference to Novacaine", by W. S. Goldsmith, Atlanta; "Treatment of Cerebrospinal Meningitis by Drainage of the Lateral Ventricle" by R. V. Martin, Savannah.

There were three papers on appendicitis which was a great surgical problem in those days. These were by R. M. Harbin, of Rome, George R. White, Savannah, and L. C. Fisher, Atlanta. Many of you remember the problems in those days when so many acute appendicitis cases had been filled with morphia for two or three days before seeking surgical intervention. In fact, if I may be allowed to quote a harmless blurb of my own, in the year book for 1913; I wrote a verse as follows:

"Appendicitis versus Opiates

Belly ache

Opiate

Operate

Undertake."

Very short, but, then, it was very much to the point.

Many other excellent papers were read before the assembly but unfortunately quite a few of them had to be read by title as the good doctors did not have time enough to listen to all of them.

The secretary, then as now, was fussing with the County Societies about getting members' dues in so that he could remit to the American Medical Association. He also felt the necessity for placing an organizer in the field which would certainly have been approved by Dr. Poer had he been there at that time.

The membership in 1913 was almost exactly one-half of the figures for today.

The following quotation was from the report of the secretary. It could have been printed in one of our current journals just prior to last November, and would have been equally applicable:

" . . . The recent medical agitation in England is making its influence felt in America and efforts will be made during the present session of Congress to pass certain laws containing certain of the English plans and eventually leading up to a fixing by law of

the fees of physicians upon such a low scale that living under present conditions would be reduced to a bare existence. This may seem rather far fetched but unless the profession unites and takes time by the forelock we will have within the next five years, such a fight on our hands as few have ever dreamed of."

The President, in 1913, was Dr. W. W. Pilcher, and the Secretary was Dr. W. C. Lyle.

New officers were elected as follows: President, Ralston Lattimore, Savannah; First Vice President, J. D. Chason, Bainbridge; Second Vice President, S. R. Roberts, Atlanta; Secretary-Treasurer, W. C. Lyle, Augusta.

Details of the 1953 meeting will probably appear in this issue of the *Journal*. Let us note, however, the number of distinguished out-of-state speakers, who will be in Savannah in May:

Louis H. Bauer, President, American Medical Association.

Julian P. Price, Editor, The Journal of the South Carolina Medical Association, Florence, N. C.

Shaler A. Richardson, Editor, The Journal of the Florida Medical Association, Jacksonville, Fla.

Robert D. Moreton, Fort Worth, Texas.

Alton Ochsner, New Orleans, Louisiana.

Heyworth N. Sanford, Chicago.

Robert D. Moreton, Fort Worth, Texas.

Lemuel C. McGee, Wilmington, Delaware.

J. P. Sanders, Shreveport, Louisiana.

Cyrus C. Sturgis, Ann Arbor, Michigan.

Robert Bryan Carr, Presiding Judge, Alabama

Col. Joseph R. Shaeffer, Washington, D. C.

Louis L. Friedman, Birmingham, Alabama.

Arthur L. Conrad, Chicago.

Court of Appeals, Montgomery, Alabama.

Duncan E. Reid, Boston, Massachusetts.

Sydney Jacobs, New Orleans, Louisiana.

As you will see from the above, it will be a real treat for anyone to attend the 1953 meeting in the beautiful City of Savannah. Let's make it a record-breaker!

EMORY UNIVERSITY SCHOOL OF MEDICINE

Announces Its First Course

on

The Use of Radioactive Isotopes In Clinical Medicine

June 8 thru 19, 1953

REGISTRATION FEE, \$100

This will include two standard books on this subject sent on receipt of the fee. These are to be read before beginning the course.

The group will be limited to 12 persons; minimum, 5.

For Information: Dir. of Postgraduate Education, Emory University School of Medicine, 36 Butler St., S. E., Atlanta 3, Georgia.

CONTENTS OF COURSE

Radioactivity and Radiation; Interaction of Radiation with Matter; Detection and Measurement of Radiation from Radioactive Sources; The Principles and Practice of Health Physics, Monitoring, Disposal, and Safety Regulations; Indications for the Use of Isotopes in Medicine; Analysis of the Case Histories of Treated Patients; Presentations of Treated Patients; Administration of Isotopes to Patients Selected for Treatment; Care and Control of Radioactive Patients; Follow-Ups on Treated Patients.

Approximately half the time will be devoted to the clinical phases; the remainder will be divided about equally between discussion of theory and laboratory experiments directly applicable to clinical use.



On The Bulletin Board

Current AMA Policy on Doctor Draft Legislation

Representatives of the American Medical Association met in Washington last month to review the new "doctor draft" bill which the Department of Defense will present to Congress. The AMA policy and position on any extension or revision of the law was presented to the Department of Defense and is incorporated in the following points:

(1) Any proposed legislation should specifically extend the primary obligation of physicians now classified in priorities 1 and 2 who are not called into service before July 1, 1953.

(2) An amendment should be suggested to the basic Selective Service Act which would obligate physicians covered by the basic Act for military service without permitting deferments because of dependency or marital status.

(3) The Association should advocate adoption of legislation to provide for the recognition of military service since Sept. 1, 1939, with countries which were allies of the U. S.

(4) The present maximum age—registration, age 50; obligation to serve, age 51—should be preserved.

(5) The present law should be amended to require registration of physicians, under age 50, who do not have reserve commissions in the armed services medical corps.

(6) Physicians who have not served since Sept. 16, 1940, should be called according to age—youngest men first—after physicians currently classified in priorities 1 and 2 have been called up or deferred for reasons of essentiality or physical disability.

(7) Physicians with military service since Sept. 16, 1940, should be called according to past service—those with the least amount of service first—after physicians currently classified in priorities 1, 2 and 3 are called up or deferred for reasons of essentiality or physical disability.

(8) No distinction should be made between service in World War II and service since June, 1950.

(9) The present concept of deferring physicians regardless of their priority classification if they are essential to the national health, safety or interest should be continued.

(10) Legislative authority to establish national and state medical advisory committees to the Selective Service System should be continued.

(11) Any extension of the doctor draft law should be limited to one year.

(12) In an effort to insure a more equitable utilization of medical manpower by the armed services, the Association recommends the establishment of a

new position as Assistant Secretary of Defense for Health Affairs. It appears that the proper way to provide for this would be by an amendment to the National Security Act of 1947, as amended.

It was also recommended that a lesser period of service be established for those physicians who had at least 12 months of prior military duty since Sept. 16, 1940.

National Advisory Committee to the Selective Service System

INFORMATION BULLETIN VOLUME IV. NO. 10

Item II—Calling of All Priority III Physicians Under 36

Present calls include Priority III physicians under 36 years of age. It is not expected that it will be necessary to go over that age between now and the termination of the Law on June 30.

The Director of Selective Service has issued the following advice:

"Each State Director of Selective Service is requested to expedite the physical examination of physicians and dentists classified in Class I-A or Class I-A-O who are in Priority I, II or III and have not been examined.

"It is requested that both immediate and follow-up action be taken to secure the results of physical examinations from the Armed Forces Examining Stations for physicians and dentists who are in Priority I, II or III."

Civil Service

The United States Civil Service Commission has announced a new examination for medical officers for filling positions in various specialized fields of medicine, with salaries ranging from \$5,940 to \$10,800 a year. The positions are principally in the Bureau of Indian Affairs located on reservations west of the Mississippi River and in Alaska. A few positions may be filled in the Fish and Wildlife Service. Applicants must be fully qualified as doctors of medicine, and for most positions must be currently licensed to practice medicine and surgery in a State or Territory of the United States. Appropriate experience is required.

Further information and application forms may be obtained from the U. S. Civil Service Commission, Washington 25, D. C., or from most first- and second-class post offices. Applications will be accepted until further notice by the Board of U. S. Civil Service Examiners, Bureau of Indian Affairs, Department of the Interior, Washington 25, D. C.

New Drugs



Recent Additions to the Drug Treatment of Hypertension

In probably no other disease have as many promising drugs been introduced with an enthusiasm which has been short-lived and rather disappointing as is the case in hypertension. It is apparent, however, that in most instances success has been sufficient to warrant the hope that eventually a satisfactory answer will be forthcoming. At present two drugs appear to be creating the greatest excitement.

Hydrazinophthalazine (Apresoline)*

This is a drug of rather unusual pharmacological properties. In experimental animals and patients, it produces a slowly developing and rather prolonged hypotension. It has definite adrenergic blocking properties although it seems quite apparent that the entire action of the drug cannot be explained by its effects on the peripheral sympathetic nervous system. The most striking pharmacological effect seen is the maintenance of normal blood flow through the kidney and the brain even though the blood pressure has fallen to a considerable extent. The explanation of these rather anomalous effects is at present lacking. By itself Apresoline produces rather frequent side actions chief among which is an annoying headache.

Rauwolfia serpentina

The newest addition to the list of drugs used in the treatment of hypertension is derived from the plant *Rauwolfia serpentina*. The crude root or alcoholic extracts of the root have long been used in India for the treatment of a wide variety of diseases, including hypertension. Recent pharmacological and clinical work has indicated that this root does contain material with a striking action. In dogs, it has been shown to prevent the pressor action of epinephrine, relax the nictitating membrane, increase gastrointestinal motility and slow the heart rate, the first three of which appear to come from blockage of the sympathetics. In addition, on chronic administration, there is evidence of depression of the central nervous system.

Similar effects have been observed in patients with hypertension. After three to six days of treatment the pulse slows, there is a moderate fall in blood pressure and a rather characteristic sedative effect. Occasionally as side actions, there is an increase in bowel movements and some nasal congestion. Although the effects of *Rauwolfia* itself in hypertension are not spectacular, in combination with other anti-hypertensive drugs such as *Veratrum* alkaloids or Apresoline highly satisfactory results have been obtained. (Wilkins and Judson, *New England Journal of Medicine* 245: 48, 1953). A margin of safety of

Rauwolfia appears to be wide and there is a potentiation of the anti-hypertensive effects of the more potent drugs.

Considerable effort has gone in to the attempted isolation of the active principles of the crude root with incomplete success as yet. It is likely that in the near future samples of the crude root will be made available for general distribution.

ARTHUR P. RICHARDSON, M.D.

New Training Course Offered

A training course for cardiovascular investigators will be offered by the Department of Physiology and Pharmacology, Medical College of Georgia. This twelve months training program in the disciplines of cardiovascular research, for a limited number of qualified individuals, will be supported by the National Heart Institute, U. S. Public Health Service. The course will begin July 1, 1953. Drs. W. F. Hamilton and R. P. Ahlquist will be in charge.

To accelerate the development of available qualified personnel for research in cardiovascular problems, a year's planned training will include the following. Formalized technical training in various research methods employed on humans and animals. Assistance of qualified investigators in basic animal research; Professors Philip Dow and John Remington and Associate Professor Robert Alexander will head such research groups. Supervised experience in independent research and manuscript preparation will conclude the training program.

Graduates in medicine or related sciences who are highly recommended and acceptable to the Program Directors are eligible. There are no tuition fees. The research traineeships carry an annual stipend of \$3400, plus an allowance of \$350 for each dependent. First-class transportation will be furnished a research trainee (but not his dependents) from his home or institution of residence to Augusta, Ga. Return transportation is not provided.

For queries or application forms write: Dr. W. F. Hamilton, Department of Physiology, or Dr. R. P. Ahlquist, Department of Pharmacology, Medical College of Georgia, Augusta, Ga.



A. M. E. F. Page

The following physicians, listed by county medical society, have contributed to the AMERICAN MEDICAL EDUCATION FOUNDATION in March, 1953. Those making their contribution direct to the AMEF Headquarters may not be listed unless official notification has been received therefrom.

BARROW COUNTY

W. T. Randolph, Winder
J. R. Whitley, Winder
L. W. Moore, Winder

CRISP COUNTY

C. C. Goss, Ashburn
Woodrow Goss, Ashburn
O. T. Gower, Jr., Cordele
C. E. McArthur, Cordele
L. E. Williams, Cordele
H. J. Williams, Cordele
P. L. Williams, Cordele
P. L. Williams, Jr., Cordele
L. O. Wooten, Cordele

WHITFIELD COUNTY

George L. Broaddrick, Dalton
Earl T. McGhee, Dalton
Paul L. Bradley, Dalton
D. Lloyd Wood, Dalton
Eli A. Rosen, Dalton
Brook F. Summerour, Dalton

H. L. Erwin, Dalton
Truman W. Whitfield, Dalton
Albert M. Boozer, Dalton
Lloyd C. Yeargin, Dalton
James N. Mullins, Chatsworth

Doctors Help Support Medical Schools

Nearly 37,000 physicians contributed more than \$3,150,000 in direct support of medical education last year. This total, however, does not include amounts given for buildings, endowments, scholarships, research and other special purposes. Dr. Donald G. Anderson, secretary of the AMA's Council on Medical Education and Hospitals, announced that reports from 76 of the country's 79 medical schools indicate that more than 29,000 doctors gave \$2,258,534 directly for teaching budgets.

The American Medical Education Foundation raised \$906,553 of the total from more than 7,000 individual contributions. The AMEF's 1953 fund-raising drive has been launched with a third gift of \$500,000 from the AMA. Since its organization two years ago, the Foundation has raised more than two million dollars from the medical profession for contribution "without strings attached" to medical schools.



In the Editor's Mail

To the Editor:

The Part Played by Charles T. Jackson In the Discovery of Surgical Anesthesia

"Well, doctor, you have the advantage of us other claimants to the first discovery of sulphuric ether as an anesthetic, but we have the advantage of having first published it to the world."

These are the words of Dr. Charles T. Jackson spoken to Dr. Crawford W. Long when he visited Dr. Long in Athens, Georgia, March 2nd, 1854, and recorded by C. H. Andrews, who was present during the interview. And yet, Edward Waldo Forbes, writing in the *Harvard Alumni Bulletin*, February 7, 1953, under the title, "He Found The Use Of Ether," gives Jackson credit for making the discovery. But Jackson never spoke truer words than when he admitted that Long was the real discoverer.

It is said that the purpose of Dr. Jackson's visit to Long was to convince himself that the Georgia physician was really the first to use anesthesia in a surgical operation, and if so to persuade Long to join with him in laying their claims together before Congress so as to win the award of \$200,000 which was being asked for bestowing the great boon upon humanity. From Jackson's statement apparently he was assured of Long's priority, but the latter would not agree to claim anything with him conjointly, and only replied: "My claim to the discovery of sulphuric ether as an anesthetic rests upon the fact of my use of it on March 30, 1842, of which I have undisputable evidence under oath and from reputable citizens."

The author of "He Found The Use Of Ether" shows that he is unfamiliar with the history of the discovery of anesthesia when he writes that Crawford Long discovered the anesthetic properties of ether

independently about a month after Jackson, but that "he tried in vain to develop the use of it." As a matter of truth Dr. Long employed ether anesthesia successfully in at least seven surgical operations before Morton gave his first demonstration, and continued to use it regularly during the remainder of his life.

What are the circumstances connected with Jackson's alleged discovery? Two remarkable facts stand out: first, that Dr. Jackson was not sure of the exact date of the event; and second, no one else was present to witness his experiment. He said that his discovery took place "sometime in February, 1842, which strangely enough was just one month preceding Long's authentic accomplishment.

In his *Manual of Etherization* Dr. Jackson explains that alone in his laboratory he seated himself in a rocking chair and began inhaling ether which was soaked on a towel, and gradually went asleep. How long he remained in this condition he did not know, but finally he woke up. From this experience he inferred that he could have been operated upon painlessly while he was asleep, and so he had discovered anesthesia! But he had only discovered a hypnotic drug, and had not discovered surgical anesthesia, which was what the world was waiting for. No operation was done while he was asleep, and he did not know whether one could be done successfully. The English scientist, Sir Humphry Davy, had found out forty-seven years before that nitrous oxide gas would produce such hypnosis, and had suggested its use as a surgical anesthetic. But Crawford Long did not stop at theorizing about these things; he was the first to possess the initiative and courage to put the idea into practical application in a surgical operation, which he did successfully, and thus he became the discoverer of surgical anesthesia.

Charles T. Jackson graduated from Harvard College in medicine in 1829, but did not practice his profession. Instead he studied chemistry and geology, and established a distinguished record in these sciences, in America and abroad. It is believed that he suggested to Morton, the Boston dentist, the idea of trying ether as an anesthetic agent, which Morton at first admitted, but later denied; while Jackson agreed to claim the discovery conjointly with Morton, and afterwards wrote his friends in Europe that he alone was responsible for the discovery.

The late Dr. Joseph Jacobs, Atlanta pharmacist, who as a boy was employed in Dr. Long's drug store in Athens, and who was a thorough student of the story of the discovery of anesthesia, always insisted that Jackson learned of the success of ether anesthesia in an operation from Long, and carried the information to Morton in Boston. Many opportunities were offered, and this is a reasonable supposition when we remember that Jackson, the geologist, made several trips to the gold mines at Dahlonega, Georgia, at about the time Dr. Long was performing his first operations under ether. It was characteristic of Jackson also to attempt to confiscate the achievements of other men and claim them for his own. Thus he made a strenuous effort to capture the invention of the telegraph from Morse, and laid deep plans to

gain control of the wounded Alexis St. Martin from William Beaumont that he might carry on the historical experiments on the physiology of the stomach which Beaumont was conducting so brilliantly. Then he tried to sieze the invention of gun cotton from Schonbein, and finally claimed that he and not William Harvey had discovered the circulation of the blood! And so it is easy to believe that this covetous scientist would deprive Crawford Long of the distinction which rightfully belongs to him.

FRANK K. BOLAND, SR., M.D.

To the Editor:

I have been advised by Mr. Alfred Jackson of the State Journal Bureau of your acceptance for publication, in the *Journal of the Medical Association of Georgia*, recent releases in the way of full page ads explaining the functions of the various Councils of the American Medical Association and their value to physicians.

We think it is highly important that every physician appreciates what these Councils are doing. This better appreciation on their part will no doubt make itself felt indirectly to manufacturers who cooperate with the official journals of the State Medical Associations, as well as The Journal of the A.M.A.

We are sincerely grateful to you for the acceptance of these releases and their appearance in your good publication.

THOMAS R. GARDINER
Business Manager
American Medical Association

Dear Doctor:

On account of the requested statement has not been received—nor is it expected—a check is enclosed in anticipation of continued absence of same.

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Cordially,
W. H. WYNN, JR.

P.S.: I hate folks who phone for medical advice for free—on account of the doctor is reluctant to charge. I have to prove to myself that with me, it's only because it's more convenient and quicker.



The Bookshelf

BOOKS RECEIVED

MAN AND EPIDEMICS: By C. E. A. Winslow, 246 pages. Princeton University Press, Princeton, N. J., 1952. Price \$4.000.

CANCER IN MAN: By S. Peller, M.D. 556 pages with graphs and 85 tables. International Universities Press, New York, New York, 1952. Price \$12.000.

LETTERS TO A DOCTOR'S SECRETARY: By Anna Davis Hunt. 75 pages. Second printing. Medical Economics, Inc., Rutherford, N. J. Price \$2.00.

ADRENAL CORTEX: Transactions of the Third Conference held November 15-16, 1951. Edited by Elaine P. Ralli, 204 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.25.

CYBERNETICS: Transactions of the Eighth Conference held March 15-16, 1951. Edited by Heinz Von Foerster. 240 pages. Josiah Macy, Jr., Foundation, New York. Price \$4.00.

CONNECTIVE TISSUES: Transactions of the Third Conference held February 14-15, 1952. Edited by Charles Ragan, M.D., Associate Professor of Medicine, College of Physicians and Surgeons, Columbia University. 166 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.50.

PROBLEMS OF CONSCIOUSNESS: Transactions of the Second Meeting, March 19-20, 1951. Edited by H. A. Abramson. 180 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.25.

FACTORS REGULATING BLOOD PRESSURE: Transactions of the Fifth Conference held February 15-16, 1951. Edited by Benjamin W. Zweifach and Ephraim Shorr. 238 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.75.

COLD INJURY: Transactions of the First Conference held June 4-5, 1951. Edited by M. Irene Ferrer. 248 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.25.

BLOOD CLOTTING AND ALLIED PROBLEMS: Transactions of the Fifth Conference held January 21-22, 1952. Edited by Joseph E. Flynn, M.D. 368 pages. Josiah Macy, Jr., Foundation, New York. Price \$4.95.

RENAL FUNCTION: Transactions of the Third Conference held October 18-19, 1951. Edited by Stanley E. Bradley. 210 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.50.

SHOCK AND CIRCULATORY HOMEOSTASIS: Transactions of the First Conference held October 22 and 23, 1951. Edited by Harold D. Green, M.D. 245 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.50.

PROBLEMS OF AGING: Transactions of the Fourteenth Conference, September 7-8, 1951. Edited by Nathan W. Shock. 138 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.00.

NERVE IMPULSE: Transactions of the Third Conference, March 3-4, 1952. Edited by H. Houston Merritt, M.D. 176 pages. Josiah Macy, Jr., Foundation, New York. Price \$3.50.

METABOLIC INTERRELATIONS: (With Special Reference to Calcium): Transactions of the Fourth Conference, January 7-8, 1952. Edited by Edward C. Reifstein, Jr., M.D. 262 pages. Josiah Macy, Jr., Foundation, New York. Price \$4.50.

ELECTRONOLOGY: By David J. Calicchio, M.D. 119 pages. Cloth Binding—Indexed. Meador Publishing Company, 324 Newbury Street, Boston 15, Mass. 1953. Price \$2.00.

LIVER INJURY: Transactions of the Eleventh Conference held April 30 and May 1, 1952. 265 pages. Edited by F. W. Hoffbauer. Josiah Macy, Jr., Foundation, New York. Price \$4.00.

BIOLOGICAL ANTIOXIDANTS: Transactions of the Fifth Conference held November 30, December 1, 1950, New York, N. Y. Edited by Cosmo G. MacKenzie. Published by Josiah Macy, Jr., Foundation, New York. Price \$3.75.

SURGERY AND THE ENDOCRINE SYSTEM: By James D. Hardy, M.D., F.A.C.S., Assistant Professor of Surgery, University of Tennessee Medical College. 153 pages. W. B. Saunders Company, Philadelphia and London. 1952. Price \$5.00.

THE UNIPOLAR ELECTROCARDIOGRAM: A Clinical Interpretation. By Joseph M. Barker, M.D., F.A.C.P. 655 pages. Appleton-Century-Crofts, Inc., New York. Price \$12.50.

THE COMPLETE PEDIATRICIAN: By W. C. Davison, Professor of Pediatrics, Duke University School of Medicine, Sixth Edition. 256 pages (index excluded). Duke University Press, Durham, N. C. Price \$4.75 (cash), \$5.00 (billed).

HEALTH INSTRUCTION YEARBOOK 1952: By Oliver E. Byrd, Ed. D., M.D., Professor of Health Education and Director of the Department of Hygiene, School of Education, Stanford University. 232 pages. Stanford University Press. Price \$3.50.

REVIEWS

ELECTROCARDIOGRAPHY IN PRACTICE: By Ashton Graybiel, M.D., Paul D. White, M.D., Louise Wheeler, A.M., and Conger Williams, M.D. Third Edition. W. B. Saunders Company. 1952. Price \$10.00.

This is the third edition of the *Atlas of Electrocardiography* written by Dr. Ashton Graybiel and Dr. Paul Dudley White. It is gratifying to note that the names of Dr. Conger Williams and Miss Louise Wheeler have been added as co-authors of the new edition.

The book has been entirely rewritten and amplified. The current status of the unipolar limb and precordial leads is discussed. A brief discussion of vector electrocardiography has been added in order to indicate that work of such a nature is underway.

There are eight parts and 22 well organized chapters written in a concise and lucid manner. Diagrams that have become classic over the years, have been reproduced and give strong emphasis to certain important points. For instance, the first diagram in the book shows the electrocardiogram of the fly-catching leaf *Dionaea* reproduced from work done by Burden-Sunderland in 1888. Such a diagram implies that tissues other than the heart have electrical properties and perhaps much can be learned from studying them. Part I presents the physiologic principles and describes in a very interesting way the operation of the galvanometer. Part II deals with Methodology. Part III is important and interesting and deals with the normal electrocardiogram and its variations. Here the electrocardiographic effects of respiration, standing, over-ventilation, fright, exercise, exposure to cold and anorexia are demonstrated in normal subjects. Such facts cannot be over-emphasized since many are still unaware that "apparently" abnormal electrocardiograms can result from many physiologic maneuvers even in normal subjects. Part IV is devoted to a discussion of the arrhythmias and various conduction defects. An earnest effort is made to replace the term "auricular" with the more correct term "atrial." For instance, a patient has atrial fibrillation, not auricular fibrillation. Part V deals with the electrocardiographic alterations due to drugs and chemicals. No mention is made in the discussion of digitalis that the Q-T interval is frequently shortened. In Part VI the various electrocardiographic patterns are described. This material is largely descriptive with little mention of the underlying electrical forces which produce such patterns. The same comment applies to Part VII where the electrocardiograms of etiologic types of heart disease are discussed. Part VIII shows electrocardiograms for practice in interpretation.

The entire book reflects the work of experts and the authors are to be congratulated. The new book is beautifully bound and is more conveniently shaped than the previous edition.

—J. W. H.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY: By Francis Heed Adler, M.D. Philadelphia, W. B. Saunders Company, 1953. Fifth Edition. 488 pages. Illustrated with 281 figures and 26 color plates, and index. Price \$7.50.

This book represents the combined efforts of two of America's most capable and highly respected ophthalmologists. The late Dr. Sanford R. Gifford, who was a great clinician, writer, investigator, and teacher, wrote the first edition that was published in 1938. Dr. Adler, equally famous, has done a marvelous job of reediting the last editions, and keeping the contents up to date, especially in the field of therapeutics, including the recent developments in antibiotics and the use of ACTH and cortisone.

This textbook is intended primarily for undergraduate students in ophthalmology and contains only the carefully selected material that will fit his needs as a general physician. Such subjects as refraction, and the technic of ophthalmic operations have been omitted. The first 117 pages concerns the routine examination of the eye, and its general physiology, and function. In the next 272 pages the most common diseases and abnormalities involving the different clinical conditions is discussed briefly and systematically, in such a way that makes this edition a practical manual instructing the general physician in what cases he may himself safely treat and specifically how this should be done.

The sections on the hypertensive diseases and diabetes, the field of ophthalmology of most concern to the general physician, has been considerably enlarged in this edition. These conditions are discussed even more fully than that usually found in standard textbooks of ophthalmology, and therefore should be useful even to ophthalmologists. The later chapters on neuro-ophthalmology, and medical ophthalmology are most outstanding, each a virtual store house of condensed information concerning the eye manifestations of these disorders. It has been said, and rightfully so, that the chapter on neuro-ophthalmology is the best 40 pages on that subject in the English language!

—A. V. H.

OPERATING ROOM TECHNIC: By St. Mary's Hospital, Rochester, Minn. Fourth Edition. W. B. Saunders Company. Price \$6.50.

"Operating Room Technic," compiled and written by the Sisters of St. Francis, St. Mary's Hospital, Rochester, Minnesota, is the outgrowth of their original manual, "The Operating Room—Instructions for Nurses and Assistants," which was written in 1924 and revised for the third time in 1937. The present volume has been completely rewritten to include recent advances in operative surgery, to add new procedures, and to revise others. In general, it is an excellent reference book for operating room supervisors, nurses, and assistants.

Operative procedures are divided into sections—general, orthopedic, neurologic surgery, urology, and peroral endoscopy. A short section is devoted to special therapeutic procedures.

Each chapter begins with an outline listing the

various procedures presented in it, and the basic instrument set-ups needed. Individual procedures follow, still in outline form, giving the definition of the procedure, position, drape, the particular instruments required, drains, sutures, and, briefly, the main steps in the procedure itself. Illustrations permit assistants to form an excellent general idea of the nature of the surgical procedure to be performed. The outline of instruments listed for each procedure is sufficient to permit performance of the operation even if additional supplies are unavailable. With this as a guide, competent nurses may anticipate the peculiarities of the surgeon whom she is assisting and the variations he might make in the use of instruments and supplies. The book should be extremely helpful to the uninitiated in the recognition of various types of instruments and in the efficient arrangement of them for use by the operating team.

The duties of members of the surgical team, the carrying out of an educational program in the operating room, and a brief summary of the supplies needed are enumerated in short chapters.

The book includes thirteen pages of illustrations of instruments used in general, orthopedic, and neurologic surgery.

"Operating Room Technic" is not intended to serve as a guide or text for the actual technics in performing surgical procedures, but it does constitute a quickly accessible reference for the technical staff in preparing for an unfamiliar procedure or one about which their ideas may be hazy.

—F. W. C.

CANCER IN MAN: By S. Peller, M.D. International University Press, New York, 1952. Price \$12.00.

In his detailed review of the theories relative to the nature and etiology of cancer, research in the field of neoplasia, and the epidemiology of cancer, the author step by step lays the basis for the plan he proposes for the attack on cancer. He minimizes the applicability to man of the work on experimental animals and the value of the work in the chemical and biochemical laboratories, rather choosing to be guided by his own interpretation of clinical observation and study of statistical material. He feels that "A cured cancer leaves an increased resistance to the development of another primary tumor in some other part of the body." And he suggests that it might be possible to forestall "the development of a highly malignant primary tumor by provoking in early life a skin epithelioma, curable in close to 100 per cent." He predicts that the morbidity and mortality from cancer might be reduced by 90 per cent by this means.

The theory of human cancer being an immunizing disease is not a new one. The clinical and statistical basis for the author's conclusions is open to great question and his theory will find little acceptance among observers in the field. The evidence at hand rather leads most observers to feel that the presence of one cancer in an individual indicates a greater likelihood of the development of another primary by the individual.

While this book is of some interest to one devoting

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the major portion of his time to cancer, it can not be recommended for the general practitioner.

MAN AND EPIDEMICS: By C. E. A. Winslow, 246 pages. Princeton University Press, Princeton, N. J., 1952. Price \$4.00.

In the words of the author, "This book was written in the belief that there is an increasing body of readers among the general public who are interested in the progress of modern knowledge, who would like to know by what roads the science of public health has reached its conclusions and what results it has achieved."

An American citizen today may obtain an abundance of pure water from a faucet and he can enjoy a safe milk supply of sanitary quality. He can eat in a public restaurant without fear of infection and he can travel about without fear of insect- or animal-borne diseases. Too often these accomplishments are taken for granted. This book presents an account of the research, planning and scientific practices which made these things possible.

The conditions under which man lived prior to the twentieth century are vividly portrayed. Many of the great epidemics of the past are described. At the same time, the environmental conditions which contribute to the spread of infection are made clear.

The reader will become familiar with many of the communicable diseases, the manner in which they spread and the methods employed for control. He will become acquainted with many of the prominent names in medical literature. He will learn the details of sanitary practices. In short, he will become familiar with the steps by which man succeeded in controlling his environment.

In contrast to the conditions which now prevail among the more advanced nations, the reader will also become acquainted with the problems of the under-developed areas of the globe which account for two-thirds of the world's population.

Although written primarily for the general public, this book provides a philosophical and historical background which is of interest to the professional worker.

About Our Contributors



ERNEST FELBER, M.D., of Atlanta, contributed the article "Acynchrous Bilateral Benign Papilloma of the Ureter with Subsequent Cancer of the Ureteral Stump, Bladder and Vagina." Dr. Felber graduated from Deutsche Universitat Medizinische Fakultat, Prague, in 1911, and is a specialist in urology.

J. D. MARTIN, JR., M.D., author of the work "Factors Influencing the Prognosis of Carcinoma of the Colon," is a graduate of Emory University School of Medicine, 1926. An Atlantian, Dr. Martin is Clinical Professor of Surgery at Emory University School of Medicine, Atlanta.

ROBERT L. BROWN, M.D., of Atlanta, wrote the article "Tumors of the Neck." A graduate of Harvard Medical School, 1933, Dr. Brown is Clinical Assistant Professor of Surgery (Neoplastic Diseases) at Emory University School of Medicine, Atlanta.

AUGUSTIN S. CARSWELL, M.D., of Augusta, contributed the article "Car Window Fractures of the Left Elbow." Dr. Carswell, a graduate of the Medical College of Georgia, Augusta, 1945, is resident at the University Hospital, Augusta.

RICHARD TORPIN, M.D., of Augusta, who wrote the article "Constriction Ring Dystocia: Report of Two Cases Rather Intensively Studied Among 17,000 Labors," is a graduate of Rush Medical College, Chicago, 1917. Dr. Torpin is Chairman and Professor, Department of Obstetrics and Gynecology at the Medical College of Georgia, Augusta.

HENRY GREENE, M.P.H. and J. E. McCROAN, JR., Ph.D., of Atlanta, contributed the article "Residual Typhus Fever in Georgia." Mr. Greene is in the Division of Typhus Control and Dr. McCroan is in the Division of Epidemiology of the Georgia Department of Public Health.

The NEW YORK POLYCLINIC

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THE DEAN, 345 West 50th Street, New York 19, N. Y.

Savannah, known far and wide as "The Hostess City of the South", has truly earned this distinction. For many years this charming old southern city with its fine hotels, delightful recreational spots, prolific natural beauty and friendly citizens has entertained thousands of "conventioners." So ideal is Savannah that many of the convening groups return year after year to partake of her graciousness.

Association members and their wives will quickly discover that Savannah is a City of contrasts. From the lace-like iron work of its unique balconies and porches to the might and sinew of its varied industry . . . from ever present memories of the past to the bright-eyed hopes and plans for the future . . . from the cosmopolitan air of a city acquainted with the world to the reflective wash of the ocean against the ancient shores, there is much contrast. Yet with all this Savannah emerges today as a community which has skilfully blended the old with the new, maintaining its atmosphere of by-gone generations amid the hustle and bustle of thriving commercial progress.

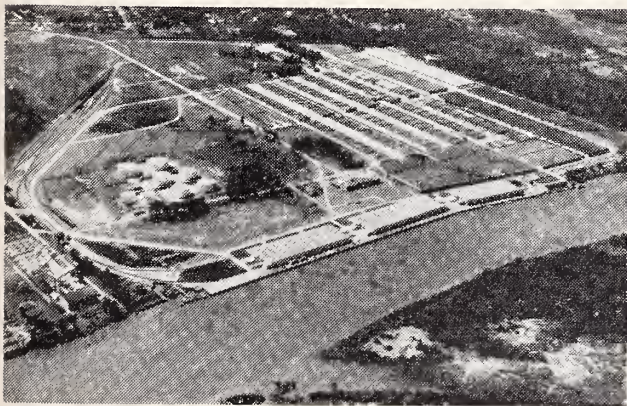


Courtesy of Savannah Chamber of Commerce

Aerial View of Downtown Savannah

SAVANNAH . . .

The Convention City



Courtesy Georgia Port Authority

Aerial view west from Savannah river showing new Savannah state docks. Facilities include four general cargo berths—one oil tanker berth with railroad and truck connections. MAG members are invited to tour part while in Savannah.





Courtesy of Savannah Chamber of Commerce

Scene in Johnson Square in the heart of downtown Savannah

To you, the visitor, Savannah offers much of interest. You may stroll along the waterfront where the port engages in the commerce of the world, and paper, cotton, naval stores, fertilizers and a host of other products move in and out to sea. Here along "The Bay" lies Factor's Walk where iron bridges cross the cobblestone runways that slope down to River Street and the docks. The former Cotton Exchange Building, now the permanent home of the Savannah Chamber of Commerce, has been handsomely renovated to accommodate the trade body. Here courteous staff members are eager to provide you with information about the community or personally conduct you on a tour of the Quarters.

Those desiring a quick change to the present need only to walk a few hundred paces to one of the main shopping thoroughfares where modern shops and stores abound. Here also are the hotels, theaters and restaurants equipped to handle the most fastidious taste.

Whether the mood calls for a quiet walk through the famous squares in this, the first of all planned cities in North America, where the pace is slowed and the mind may relax or restless energies may be expended in sports or work, you will find in Savannah ample answers to your desires. A mildness in the climate finds expression in the mean temperature (65 degrees) which promotes enjoyment in all types of work and play.

Drive through Savannah's streets and palms and water oaks join in waving to you. In early spring azaleas blind you with their colors as they would stay you from any thought of departure. Here there is a spirit, a kind of maternal concern for the guest which gives an entirely new meaning to another of

Savannah's distinctive names . . . "The Mother City of Georgia."

The Atlantic ocean lies 18 miles east of the city. The town of Savannah Beach on Tybee Island boasts excellent beaches and accommodations for those who would surf bathe or disport themselves amid the breakers. En route to the beach is Fort Pulaski National Monument. Located on Cockspur Island, the fort was forced to surrender to Federal troops who there first successfully used rifled cannon against stone masonry construction. Here Robert E. Lee as a young officer out of West Point had his first assignment during construction of the fortification.

The Savannah State Docks, a \$15,000,000 facility, were formally dedicated November 11, 1952 and are hailed as the portender of a new era in Savannah's shipping, always a mainstay in her economic structure since that eventful day in 1819 when the "S. S. Savannah" steamed down the harbor for Liverpool to become the first such vessel to cross the Atlantic.

Other historic sites of much interest to the visitor are the "Pirates House" said to be the oldest standing house in Georgia; the home of Juliette Gordon Low, founder of the Girl Scouts of America; Green-Meldrim House, headquarters of General William T. Sherman during his occupancy of Savannah; the graves of Revolutionary War hero General Nathaniel Greene and his son; The Telfair Academy of Arts and Sciences; the famed Owens-Thomas House, and many, many more.

With an old world atmosphere brought to mind every day by her old houses, quiet squares and superabundance of trees and shrubs, being in Savannah is a pleasure for all visitors. The city grows larger but keeps her ancient landmarks for the enjoyment of all. With economy activity on the increase, she is alive with the noise of progress. Plans and hopes ride high as she moves confidently ahead.

Savannah and her friendly citizens want you to come and share in the multitude of her pleasures that are always yours to enjoy.

CHARLES L. PRINCE, M.D.

Monument in memory of siege of Savannah, American Revolutionary War.

Courtesy of Savannah Chamber of Commerce



Notice to All Physicians:

COME *to* SAVANNAH

in MAY

Dr. Howard Morrison's

Open Letter to

Dr. Noble Wimberly Jones

Dear Sir:

With the greatest respect, I tender to you this invitation to meet with your colleagues in Savannah in May. The Society which will be host to the State Society is the same one which you fathered in 1804. From the original number of 14 members it now has 10 times that number.

As a man who served his state as physician, law maker and military defender you will be interested in all the changes you will find. Gone are the plantations of your friends along the Savannah River; as the growing of rice and cotton is no longer profitable to our citizens. The Hermitage is now the site of our largest industrial plant which makes paper pulp from the pines you endeavored to protect. The discovery of this process has resulted in a means of livelihood to so many; reforestation is part of the programme.

The low lands have been drained and rid of malaria. Yellow fever has not been known here in 50 years. The banks of inland waterways now afford sites for country homes and clubs where fishing, sailing and golf can be enjoyed without danger of disease. We will make a special effort to see that you have an opportunity to indulge in these pleasures.

You will also want to learn how our city has become freed of many contagious diseases through a process called vaccination and the quarantine of ships at the entrance to our port. Still later advances in medical diagnosis and treatment will be discussed at the scientific sessions in May.



HOWARD MORRISON, M.D.
President, Georgia Medical Society

Savannah is still basically the city planned and so beautifully laid out by your friend General Oglethorpe. The squares provide havens of shade in summer and the live oaks give an impression of green leafiness through the winter. But I think you will be astounded sir, by the brilliance of the flowers everywhere now. Dogwood, azalea,

spirea, wisteria and yellow banksia rose vines have survived and multiplied while the mulberry trees have all disappeared. As a reminder of one of the purposes for which our colony was founded here, the Trustees Garden area is still demarcated as such and there is an herb garden and herb shop to be found there. Nearby, near the river bluff, is the building where seamen and pirates hung out when in port. Refreshment, of a slightly different kind, may still be procured there.

Most of the visitors to the convention will stay at the DeSoto Hotel where the meetings are held. You will probably prefer to stop with your relative at Wormsloe where you grew up. It is little changed since you last saw it except that Fort Wymberly has crumbled to its foundations through disuse as we need no longer be defended against our neighbors to the South. In the woods the growth is wild and uncut as you would have it.

Down the road is Bethesda, an orphanage for boys and the oldest in our country. You probably visited there with your father. You would have

been about 15 when Mr. Whitfield brought Dr. John Hunter over from England and set up a free clinic there for the poor. A "still" which was part of the apothecary is one of its landmarks.

Please, sir, try and come. These meetings in Savannah are looked forward to by our friends all over the state. The State Society did not grow out of the one you founded but was organized by representatives from several local societies. Since then the annual meeting has been held by rotation in Atlanta, Augusta, Macon and Savannah. Savannah is the only one of these on the water and for that reason has been a favorite meeting place. It will surprise you how much the city has grown. In spite of that it retains its small-town charm and sense of personal hospitality. I hope sir, that you will come. We shall make every effort to help you do and see everything you desire and we hope to make your visit here most pleasant.

Sincerely:

HOWARD J. MORRISON, M.D.

President Georgia Medical Society



Azalea Splendor in Savannah Park



Historical Savannah

Wild Heron

WILD HERON -- OLDEST RESIDENCE *in Georgia*

While the dwelling at Wild Heron Plantation, country home of Mr. and Mrs. Shelby Myrick on the Grove Point Road in Chatham County is, according to records, the oldest residence still standing in Georgia, it is not of the "White Columned" type. Built in 1756 in a simple, farm-house style, it is comfortable, compact and set on a splendid elevation.

The plantation was named Wild Hern for the Hampshire, England, estate of Mary Goodall who became the wife of Francis Harris to whom this 800 acres of land was granted by King George II. Hern is the English contraction for heron. This plantation was owned by the descendants of Francis Harris until it was purchased by the Myricks in 1935. The landgrant hangs on the living room wall and was the deed to the place when Mr. Myrick bought it. Elizabeth Harris, daughter of Francis and Mary Harris married Douglas McLeod, a Scotch doctor sent over during the Revolution to minister to the injured. The McLeod name was carried down to the present generation, Minnie McLeod who married Robert Hull (now both deceased) and it was Mrs. Hull who sold the property in 1935.

Wild Heron stands on high ground with only a little marsh across the water front—the Grove river traverses this territory, joining with the Forest River to empty into the Little Ogeechee river about three miles below. The old folks knew how to place their houses—directly facing the south and on high ground. Certainly this latter fact accounts for the building still standing in good condition. For with all the floods that have been encountered in this part of the country for the past 200 years never has this house been flooded, neither has a storm ever blown down one piece of it, nor has lightning ever struck a single chimney. It has had the old-fashioned lightning rods, it is true, and they have been protectors, no doubt. But could anyone ever have picked a spot so well as this, so liked by the elements that it has never been bothered with the calamities which have proven fatal to many other old farm houses!

Originally this was a rice plantation and for several years after he purchased it, Mr. Myrick also planted rice there—until the artesian well used to flood the rice field became dry due to the expansion of industries on the Savannah river. About 1900

Richard McLeod, brother of Mrs. Hull the last of the Harris family to live at Wild Heron, planted hundreds of pecan trees and these are still producing many thousands of pounds of nuts annually. The wonderful satsuma grove maintained by Mr. Myrick succumbed to the freeze of 1950. Many pear trees have been planted in recent years, as well as extensive plantings of youngberries. Both white and purple scuppernong grapes have been there for years and from these has been made a wine for which the plantation is famous. Mary Hardee, (granddaughter of a slave) who still lives on Wild Heron Plantation, has such a reputation for making shrimp pilau that it has become almost imperative that shrimp pilau be served on all occasions at Wild Heron.

Most of the negroes in the vicinity are descendants of the original slaves who once cultivated the rice fields of Wild Heron. They have preserved the words and tunes of many spirituals peculiar to the group, and they often appear singing at big gatherings on the plantation.

The house itself is built of wide clapboards of hand-hewn timber and bricks brought over from England. The architecture has not been changed except to provide for some modern conveniences. There are three stories; two attic bedrooms with dormer windows; the main floor with four rooms and bath with porches extending the full length of the house both on front and back. A large dining room and kitchen as well as maid's room are in the basement with a wide screened porch at rear and a brick area-way under the front porch. Big open fire-

places are in the large rooms. Tabby is used for the dining room walls and flag stone for its floor. Most of the material in the house is original—the mantels, wainscotings, some of the flooring and most of the exterior frame. Only repairs were made in 1935 where boards were missing after long neglect. Wooden pegs were used in the construction of this dwelling.

There are no expensive antique furnishings at Wild Heron Plantation. Everything has been kept down to the farm house way of living, simple but comfortable—always hospitable.

Many picnics, barbecues and oyster roasts have been enjoyed under the great oaks where an out-door fireplace stands ready at all times for "cooking up a party."

Mrs. Myrick has been developing a formal garden just beyond the great oaks. She has built there a tea house and walled in the garden with a lace-brick wall and painted all of this white. A formal planting has been adhered to in the garden with its pattern marked with dwarf boxwood. Stone benches at the ends of the walks and a sundial are the garden ornaments. Pansies, tulips, hyacinths, azaleas, camellias, roses and other flowers in pinks, purple and lavender carry out the hostess' favorite colors—Redbud, magnolias, dogwood, wild honeysuckle, sweet shrubs, yellow jessamine, wisteria and Cherokee roses are growing naturally on this plantation where they have had their roots for generations.

MRS. SHELBY MYRICK

Telfair Academy of Arts and Sciences, Downtown Savannah

Courtesy of Savannah Chamber of Commerce



THE 103rd ANNUAL SESSION

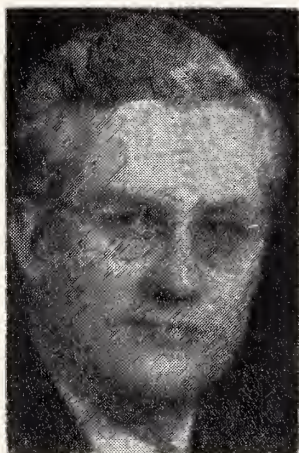
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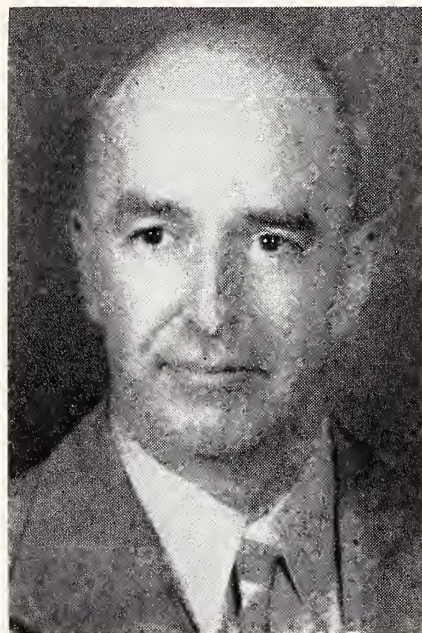
May 10-13, 1953



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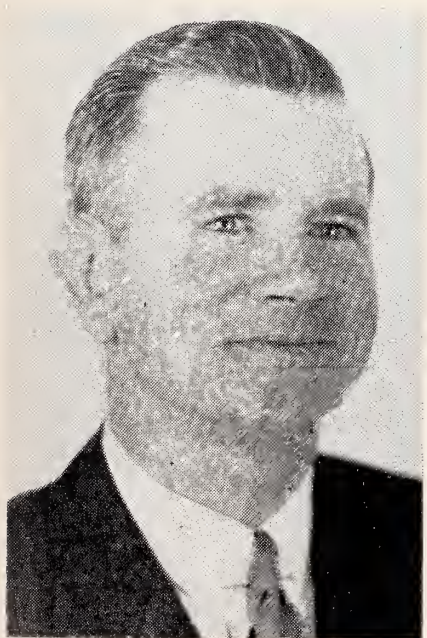
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7—D. Lloyd Wood, Dalton	1953 Session
8—Sage Harper, Douglas	1953 Session
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<i>District</i>	<i>Term Expires</i>
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3—Guy J. Dillard, Columbus	1955 Session
4—Clarence B. Palmer, Covington	1955 Session
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6—H. G. Weaver, Macon	1953 Session
7—M. M. Hagood, Marietta	1953 Session
8—J. A. Leaphart, Jesup	1953 Session
9—Charles R. Andrews, Jr., Canton	1954 Session
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	Houser, Frank
	Patton, Sam
	Ross, H. L. Jr.
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Brooks	Smith, L. A.
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Burke	Byne, J. M., Jr.
Carroll-Douglas-Haralson	Allen, C. H.
Georgia Med. Society	Elliott, John L.
	King, Ruskin
	Peterson, T. A.
Chattooga	Little, R. N.
Cherokee-Pickens	Boswell, T. C.
Clayton-Fayette	

Clarke	Greene, James A.
	Hubert, M. A.
Cobb	Garland, Charles
Coffee	Bell, E. D.
Colquitt	Funderburke, A. G.
Crisp	Williams, P. L.
Coweta	Tanner, W. H.
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DeKalb	Morse, Chester W.
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Franklin	Poole, E. T.

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Boling, Edgar	Rieth, Paul L.
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Pruitt, M. C.	

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Macon	
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Montgomery	Moses, W. M.
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	Conger, A. B., Jr.
	Hutto, George M.
	Schley, Frank B.
Newton	Paty, Robert M., Jr.

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	Wright, G. W.
	McGahee, R. C.
	Martin, J. M.
	Mulherin, C. M.
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Walker-Catoosa-Dade	Simonton, Fred
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Ware	Pomeroy, W. L.
	Smith, Leo
Warren	Cason, H. B.
Washington	Newsome, E. G.
Wayne	Pumpelly, R. A., Jr.
Whitfield	Bradley, Paul
Wilcox	
Wilkes	Wills, C. E.
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Coweta—St. John, James A., President, Newnan; Parks, J. W., Secretary, Newnan.
Lamar—Crawford, J. B., President, Barnesville; Traylor, S. B., Secretary, Barnesville.
Meriwether-Harris—Chambless, William G., President, Hamilton; Gilbert, R. B., Secretary, Greenville.
Newton—Nesbit, F. C., President, Covington; Palmer, Clarence B., Secretary, Covington.
Spalding—Oshlag, A. M., President, Griffin; Kelley, J. W., Secretary, Griffin. First Tuesday in every month.
Troup—Mitchell, John T., President, LaGrange; Easley, Curran, Jr., Secretary, LaGrange.
Upson—Blackburn, John D., President, Thomaston; Gower, Wm. J., Jr., Secretary, Thomaston. First Tuesday in each month.

FIFTH DISTRICT

5th District—Harry Lange, President, Atlanta; C. Purcell Roberts, Secretary, Atlanta. March and November.
DeKalb—Mendenhall, William Alfred, President, Chamblee; Leslie, John T., Secretary, Decatur.
Fulton—Hamm, William G., President, Atlanta; Blalock, Tully T., Secretary, Atlanta.

SIXTH DISTRICT

6th District—William Rawlings, President, Sandersville; C. H. Richardson, Jr., Secretary, Macon. Last Wednesday in June—First Wednesday in December.
Baldwin—Baugh, James E., President, Milledgeville; Scott, Wilbur, Secretary, Milledgeville.
Bibb—Newton, Ralph, President, Macon; Tift, Henry H., Secretary, Macon.
Hancock—Earl, H. L., President, Sparta; Tanner, David E., Secretary, Sparta.
Jasper—Belcher, F. S., President, Monticello; Lancaster, E. M., Secretary, Shady Dale.
Jefferson—Pilcher, James W., President, Louisville; Revell, W. J., Secretary, Louisville. Each fourth Wednesday.
Laurens—Anderson, Robert T., President, Dublin; Kenney, Nell, Secretary, Dublin.
Monroe—Bramblett, A. Walker, Jr., President, Forsyth; Alexander, G. H., Secretary, Forsyth.
Washington—McElreath, T. F., Jr., President, Tennille; Helton, Wm. S., Secretary, Sandersville.

SEVENTH DISTRICT

7th District—H. L. Erwin, President, Dalton; R. N. Johnson, Secretary, Rome. First Wednesday in April; last Wednesday in September.
Bartow—Howell, W. H., President, Cartersville; Dillard, Wm. B., Jr., Secretary, Cartersville.
Carroll-Douglas-Haralson—Denney, R. L., President, Carrollton; Reese, D. S., Secretary, Carrollton.
Chattooga—Allen, J. J., President, Summerville; Martin, Wm. P., Secretary, Summerville.

Cobb—Burleigh, B. D., President, Marietta; Cauble, G. C., Secretary, Marietta. First Tuesday of each month (except June, July, August).
Floyd—Dillinger, R. W., President, Rome; Smith, Stephen D., Secretary, Rome.
Gordon—Steele, B. H., President, Fairmount; Richardson, C. K., Secretary, Calhoun.
Polk—Chaudron, P. O., President, Cedartown; Spanjer, R. F., Secretary, Cedartown.
Walker-Catoosa-Dade—Alsobrook, Thomas W., President, Rossville; Townsend, E. M., Secretary, Ringgold.
Whitfield—Boozer, A. M., President, Dalton; King, Hubert U., Secretary, Dalton. Third Wednesday of each month.

EIGHTH DISTRICT

8th District—F. G. Eldridge, President, Valdosta; Sage Harper, Secretary, Douglas. Second Tuesday—April and October.
Appling—Kennedy, F. B., President, Baxley; Brown, J. B., Jr., Secretary, Baxley.
Coffee—Jardine, Dan A., President, Douglas; Harper, Sage, Secretary, Douglas.
Glynn—Towson, L. G., President, Sea Island; Hicks, J. M., Secretary, Brunswick.
South Georgia (Berrien-Clinch-Cook-Echols-Lanier-Lowndes)—Austin, G. J., President, Valdosta; Perry, R. L., Secretary, Valdosta.
Telfair—Mann, F. R., Jr., President, McRae; McRae, D. B., Secretary, McRae.
Ware—Knight, Arthur, Jr., President, Waycross; Ferrell, T. J., Secretary, Waycross.
Wayne—Virusky, E. J., President, Jesup; Perkins, Wm. H., Secretary, Jesup.

NINTH DISTRICT

9th District—E. L. Ward, President, Gainesville; George T. Nicholson, Secretary, Cornelia. April and September.
Blue Ridge—May, L. C., President, Blue Ridge; Hicks, Thomas J., Secretary, McCaysville.
Cherokee-Pickens—Hendrix, Arthur M., President, Canton; Nichols, William, Secretary, Canton.
Forsyth—Bramblett, Rupert, President, Cumming; Mashburn James S., Secretary, Cumming.
Gwinnett—Kelley, D. C., President, Lawrenceville; Smith, R. E., Secretary, Buford.
Habersham—Henry, C. M., President, Clarkesville; Hicks, L. G., Jr., Secretary, Clarkesville. Second Tuesday of each month.
Hall—Gilbert, Ben, President, Gainesville; Smith, Martin Henry, Secretary, Gainesville.
Jackson-Barrow—Rogers, A. A., Sr., President, Commerce; Moore, Lewis W., Secretary, Winder.
Rabun—Neville, L., President, Dillard; Dover, J. C., Secretary, Clayton.
Stephens—Cleveland, P. B., President, Toccoa; Ayers, C. L., Secretary, Toccoa.

TENTH DISTRICT

10th District—A. W. Simpson, President, Washington; J. B. Traylor, Secretary, Athens. Second Wednesday—February and August.
Clarke-Madison-Oconee—Greene, J. A., President, Athens; Elder, J. D., Secretary, Winder. Third Thursday—February and August.
Elbert—O'Neil, John B., III, President, Elberton; Mickel, Cary A., Jr., Secretary, Elberton.
Franklin—Brown, Stewart D., Jr., President, Royston; Roole, E. T., Secretary, Lavonia.
Hart—Harper, George T., President, Dewy Rose; Cacchioli, Louis G., Secretary, Hartwell.
McDuffie—Riley, B. F., President, Thomson; LeRoy, A. G., Secretary, Thomson.
Morgan—Dickens, C. H., President, Madison; McGeary, W. C., Secretary, Madison.
Richmond—Philpot, W. K., President, Augusta; Mulherin, Joseph L., Secretary, Augusta.
Walton—DeFreese, S. J., President, Monroe; Thompson, Ernest, Secretary, Monroe.
Wilkes—Wills, C. E., Jr., President, Washington; Adair, M. C., Secretary, Washington.

YOUR 103rd ANNUAL

SUNDAY - MAY 10

9:00 A.M.	REGISTRATION OF DELEGATES <i>South Lobby, Hotel DeSoto.</i>
9:00 A.M.	FINAL MEETING OF COUNCIL <i>Habersham Room, Hotel DeSoto.</i>
10:00 A.M.	MEETING, HOUSE OF DELEGATES <i>Gold Room, Hotel DeSoto.</i>
2:00 P.M.	MEETING, HOUSE OF DELEGATES <i>Gold Room, Hotel DeSoto.</i>
2:30 P.M.	FILM READING SESSION <i>Georgia Radiological Society, Chatham Room, Hotel DeSoto.</i>
3:00 P.M.	ADVANCE REGISTRATION OF MEMBERS <i>South Lobby, Hotel DeSoto.</i>
3:45 P.M.	JOINT MEMORIAL SERVICE <i>Grand Ballroom, Hotel DeSoto.</i>
4:30 P.M.	OPEN PUBLIC MEETING (MAG Auxiliary sponsorship) <i>Grand Ballroom, Hotel DeSoto.</i>
6:00 P.M.	SOCIAL HOUR AND SMORGASBORD <i>For Officers, Delegates, Guests including Wives (Tickets Re- quired), General Oglethorpe Ho- tel, Wilmington Island (Special Bus Service from Hotel DeSoto to Be Furnished).</i>

MONDAY - MAY 11

8:30 A.M.	OPENING CEREMONY AND SPECIAL ANNOUNCEMENTS <i>Grand Ballroom, Hotel DeSoto.</i>
9:00 A.M.	PANEL DISCUSSION, VOCATIONAL REHABILITATION <i>Gold Room, Hotel DeSoto.</i>
9:00 A.M.	CLINICAL SESSION <i>Grand Ballroom, Hotel DeSoto.</i>
10:30 A.M.	INTERMISSION TO VIEW EXHIBITS
11:00 A.M.	CLINICAL SESSION <i>Grand Ballroom, Hotel DeSoto.</i>
12:00 P.M.	GENERAL MEETING MAG MEM- BERS <i>President's Address and Awards Nomination of Officers Grand Ballroom, Hotel DeSoto.</i>
1:00 P.M.	SPECIALTY SOCIETY LUNCHEONS
2:00 P.M.	SECTION MEETINGS <i>Hotel DeSoto.</i> GENERAL SURGERY <i>Grand Ballroom.</i> PEDIATRICS <i>Colonial Room.</i> RADIOLOGY <i>Chatham Room.</i> UROLOGY <i>Oglethorpe Club, 450 Bull St.</i>
7:00 P.M.	ALUMNI DINNERS
7:30 P.M.	DINNER MEETING, JMAG EDITORIAL BOARD <i>Oglethorpe Club 450 Bull St.</i>
10:00 P.M.	FILM "ALL MY BABIES" (MAG Auxiliary Sponsorship) <i>Restricted Showing to Physicians and wives, Gold Room, Hotel DeSoto.</i>

SESSION TIMETABLE

TUESDAY - MAY 12

9:00 A.M.	CLINICAL SESSION (Gastroenterology) <i>Grand Ballroom, Hotel DeSoto.</i>
9:00 A.M.	CLINICAL SESSION (Orthopedics and Trauma) <i>Gold Room, Hotel DeSoto.</i>
10:40 A.M.	INTERMISSION TO VIEW EXHIBITS
11:00 A.M.	GENERAL SESION <i>Grand Ballroom, Hotel DeSoto.</i>
1:00 P.M.	SPECIALTY SOCIETY LUNCHEONS
2:00 P.M.	SECTION MEETINGS <i>Hotel DeSoto.</i> PATHOLOGY <i>Habersham Room</i> INDUSTRIAL SURGERY AND MEDICINE <i>Sapphire Room</i>
3:00 P.M.	HOUSE OF DELEGATES <i>Georgia Medical Society Hall, 612 Drayton St.</i>
5:30P. M.	RECEPTION FOR MAG MEMBERS AND WIVES <i>(Host—Central of Georgia Rail- road Co.), Gold Room, Hotel DeSoto. (No refreshments served after 6:45 P. M.)</i>
7:00 P.M.	PRESIDENT'S DINNER <i>(By Subscription), Grand Ball- room, Hotel DeSoto.</i>

WEDNESDAY - MAY 13

7:30 A.M.	MAG COUNCIL BREAKFAST AND MEETING <i>Habersham Room, Hotel DeSoto.</i>
9:00 A.M.	PANEL DISCUSSION ON INSURANCE <i>Gold Room, Hotel DeSoto.</i>
9:00 A.M.	CLINICAL SESSION <i>Grand Ballroom, Hotel DeSoto.</i>
10:30 A.M.	INTERMISSION TO VIEW EXHIBITS
11:00 A.M.	CLINICAL SESSION <i>Grand Ballroom, Hotel DeSoto.</i>
12:00 P.M.	GENERAL MEETING MAG MEMBERS <i>Grand Ballroom, Hotel DeSoto.</i>
1:00 P.M.	SPECIALTY SOCIETY LUNCHEONS
2:00 P.M.	SECTION MEETINGS <i>Hotel DeSoto.</i> OBSTETRICS AND GYNECOLOGY <i>Gold Room.</i> INTERNAL MEDICINE <i>Sapphire Room.</i> CHEST <i>Chatham Room.</i>

GUEST SPEAKERS

for the MAG 103rd Annual Session



Louis H. Bauer, M.D.

Well known to all Association members is the name of LOUIS H. BAUER, M.D., of Hempstead, N. Y., President of the American Medical Association. Dr. Bauer will address the initial meeting of the House of Delegates at the Savannah Annual Session. Dr. Bauer is a graduate of Harvard Medical School and is a diplomate of the American Board of Internal Medicine, and is a Fellow of the American College of Physicians. Dr. Bauer is a past Chairman of the Board of Trustees of the American Medical Association.



Cyrus C. Sturgis, M.D.

"Some Recent Advances in Hematology" is the subject of the "Calhoun Lecture" address to be presented by CYRUS C. STURGIS, M.D., Professor of Internal Medicine and Chairman of the Department of Internal Medicine at the University of Michigan, Ann Arbor, Michigan. Dr. Sturgis is also the Director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan.

His presentation will entail a brief discussion concerning the indications for and the mode of administration of vitamin B-12, intravenous iron, ACTH and Cortisone, nitrogen mustard, roentgen therapy, urethane, radioactive phosphorus, and blood transfusions in the treatment of various hematological disorders. The disorders will include the management of patients with pernicious anemia, anemia of preg-

nancy, iron deficiency anemias, leukemia and allied disorders, and polycythemia.



Judge Robert B. Carr

Highlighting the President's Dinner at the Medical Association of Georgia's One Hundred and Third Annual Session will be guest speaker JUDGE ROBERT BRYAN CARR, of Montgomery, Alabama. Judge Carr is the presiding Judge of the Court of Appeals of Alabama.

Receiving his early education in the public schools near his birthplace at Pushmataha, Choctaw County, Alabama, Judge Carr graduated from Southern University, A.B., and from the Law Department, University of Alabama, 1917. He began the practice of his profession in Anniston, was U. S. Commissioner, 1918-20, and in 1924 was elected Presiding Judge of the Seventh Judicial Circuit. He served there until he was appointed to the Court of Appeals of Alabama in 1944. In 1946 he was elected to a six-year term, and at the death of the Presiding Judge, he became Presiding Judge of the Court of Appeals of Alabama. He was without opposition when he successfully was elected to a second term in 1952.

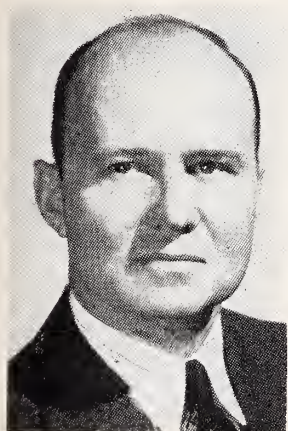


Heyworth N. Sanford, M.D.

Presenting papers on "Care of the Premature Infant" and "Some Problems in the Care of the Newborn" will be HEYWORTH N. SANFORD, M.D., of Chicago. Dr. Sanford is the Attending Pediatrician Research and Education Hospital and

Presbyterian Hospital, Chicago and Chairman of Department at both institutions. He is also the Attending Pediatrician and Head of Department of Pediatric Hematology, Cook County Hospital, Chicago. He was appointed Professor of Pediatrics, University of Illinois in 1945 and has been Acting Head of Department since 1952.

Dr. Sanford was born in Liberty, New York, and graduated from Rush Medical College. He interned at the Presbyterian Hospital, Chicago and served his residency in Pediatrics there. He did post graduate study at the University of Poitiers, France, and in Germany. After serving as Assistant in Pediatrics at Rush Medical College, Chicago, he was appointed Professor of Pediatrics.



Lemuel McGee, M.D.

Speaking on the subject of "*Dysfunction of the Colon*" and "*Operational Responsibilities of a Medical Department in Industry*" will be LEMUEL MCGEE, M.D., Medical Director, Hercules Powder Company, Wilmington Delaware. Other current affiliations of Dr. McGee are: Attending Chief in Medicine, Delaware Hospital, Wilmington; Chief, Clinic in Gastroenterology, Delaware Hospital, Wilmington; President, Medical Board, Delaware Hospital, Wilmington; and Associate in Medicine, Memorial Hospital, Wilmington.

A native of New Boston, Texas, Dr. McGee received his A.B. degree at Baylor University, Waco, Texas; his Ph.D. degree at the University of Chicago (Biochemistry and Physiology); and his M.D. degree at Rush Medical College, University of Chicago. He was the recipient of the E. R. Squibb & Son Fellowship and the National Research Fellowship while at the University of Chicago.

Serving his internship at Baylor University Hospital, Dallas, Texas, and Ralph Brown Medical Service, Presbyterian Hospital, Chicago; Dr. McGee also was a member of the faculty in Physiology and Pharmacology, Baylor University College of Medicine. Dr. McGee was Internist at the Golden Clinic, Davis Memorial Hospital, Elkin, West Virginia. And he was a Research Fellow in Medicine and Biochemistry, Medical School of Harvard University and Peter Bent Brigham Hospital.

Speaking at the Symposium on Burns, COL. JOSEPH R. SHAEFFER, M.C., USA, Washington,

D. C., will give an address on the topic "*The Mass Treatment of Burns in Atomic Warfare*." Col. Shaef-fer, a graduate of Cornell University Medical College, is Chief of the Surgical Consultants Division, Surgeon General's Office, Washington, D. C.



Walter H. Sheldon, M.D.

WALTER H. SHEL- DON, M.D., Chief Path- ologist, Emory University Hospital and Professor and Chairman, Department of Pathology, Emory Uni- versity School of Medicine, Atlanta, will present an address on "*Leptospiral Infection*." Dr. Sheldon is the Chief Pathologist at Grady Memorial Hospital, Atlanta and Consultant Pathologist, U.S.V.A.

Dr. Sheldon was born in Berlin, Germany, and received his M.D. degree at Catania, Italy. He was Assistant Pathologist at the University Pavia, Italy. He served an internship at the Children's Hospital, Boston; was resident in Pathology at Boston Lying-in Hospital and the Free Hospital for Women, Brook- line, Mass. Dr. Sheldon was also on the faculty in Pathology at Harvard Medical School and a Re- search Associate in Pathology at Boston Lying-in Hospital.



Jason P. Sanders, M.D.

JASON P. SANDERS, M.D., of Shreveport, Loui- siana, will be featured as a guest speaker at the One Hundred Third Annual Session of the Medical Asso- ciation of Georgia. Members of the Association are familiar with Dr. Sanders, who recently addressed the Georgia Chapter of the American Academy of General Practitioners and whose talk was printed in the *Journal of The Medical Association of Georgia*, January, 1953. Dr. Sanders is a graduate of Uni- versity of Texas School of Medicine, Galveston, and is Director of the Sanders Clinic in Shreveport, Loui- siana.



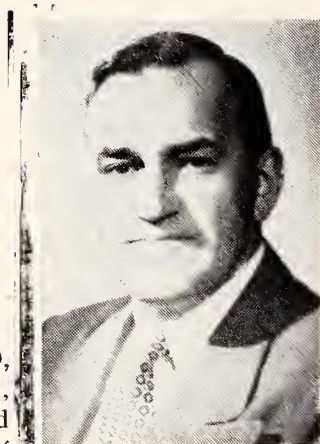
Alton Ochsner, M.D.

ALTON OCHSNER, MD., the William Henderson Professor of Surgery and Chairman of the Department of Surgery, School of Medicine, Tulane University of Louisiana, New Orleans, and the Director of the section on General Surgery, Ochsner Clinica and Foundation Hospital, New Orleans, will present two papers at the Annual Session.

The titles of Dr. Ochsner's addresses are "*Acute Cholecystitis*" and "*Early Diagnosis and Treatment of Cancer of the Stomach.*"

At the present time Dr. Ochsner is Senior Visiting Surgeon, Charity Hospital, and Surgeon-in-Chief of the Tulane Surgical Service, Charity Hospital, New Orleans; Senior Surgeon, Touro Infirmary, New Orleans; Consulting Surgeon, Illinois Central Hospital, New Orleans; Consulting Surgeon, Southern Pacific Railroad; Attending Specialist in Chest Surgery, U. S. Public Health Hospital, New Orleans; Consultant in Thoracic Surgery, Veterans Administration Hospital, New Orleans; and Consulting Surgeon, Walton County Hospital, DeFuniak Springs, Florida.

Born in Kimball, South Dakota, Dr. Ochsner graduated from the University of South Dakota, B.A., and Washington University, St. Louis, Mo., M.D. degree. With his internship under Dr. George Dock, Dr. A. J. Ochsner, had a great deal of professional training abroad, Dr. Ochsner also served on the faculties of Northwestern University and Wisconsin.



Duncan Earl Reid, M.D.

DUNCAN EARL REID, M.D., of Boston, Mass., will present two talks titled "*Controversial Aspects of Late Pregnancy Bleeding*" and "*Management of the Diabetic Patient in Pregnancy.*" A graduate of Northwestern University Medical School, Dr. Reid has received certification by the American Board of

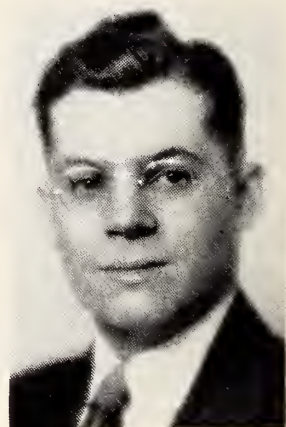
Obstetrics and Gynecology. He is also on the faculty of the Harvard Medical School, Boston, as a Professor of Obstetrics.



Robert D. Moreton, M.D.

Addresses on "*Gastrointestinal Bleeding*" and "*Barium Enema Study of the Large Intestine*" will be

presented by ROBERT D. MORETON, M.D., of Fort Worth, Texas. Dr. Moreton, a graduate of University of Tennessee College of Medicine, Memphis, is certified by the American Board of Radiology. He is a Fellow of the American Roentgen Ray Society, Radiological Society of North America, Inc., and the American College of Radiology.



Sydney Jacobs, M.D.

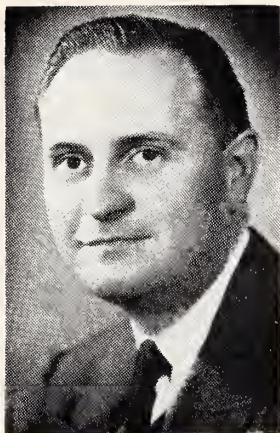
Presenting papers on the subjects of "*What to Expect of the Photofluorogram*" and "*Diabetes and Tuberculosis*" is SYDNEY JACOBS, M.D., of New Orleans. Dr. Jacobs graduated from Tulane University of Louisiana School of Medicine, New Orleans. He has been certified by the American Board of Internal Medicine and is a Fellow of the American College of Chest Physicians, American College of Physicians and the American Trudeau Society.

Dr. Jacobs is on the faculty of the Tulane University of Louisiana School of Medicine in the Department of Clinical Medicine.

LOUIS L. FRIEDMAN, M.D., Director of the Friedman Diagnostic Clinic, Birmingham, Alabama, will present a paper on "*Pneumoconiosis in Soft Coal Workers.*" Dr. Friedman was formerly Instructor in Medicine, Louisiana State University School of Medicine and Assistant Professor of Medicine and Assistant to the Dean, Medical College of Alabama.

Dr. Friedman was a graduate of the University of Arkansas School of Medicine, Little Rock, Arkansas, 1941.

Mr. Arthur L. Conrad



Mr. ARTHUR L. CONRAD, of Chicago, will address the Open-Public Meeting in Savannah, Sunday, May 10, at 4:30 p.m. in the Grand Ballroom, Hotel DeSoto. The subject of his talk is "*Are We Educating or Indoctrinating Our Children?*" Mr. Conrad, President of The Heritage Foundation, Inc., has toured the world as an officer in Naval Aviation designated in official State and War Department capacities. He has had a wide experience in business

and public relations work and is an active participant in civic and community affairs. A graduate of University of Notre Dame, DePaul University, and Loyola University, Mr. Conrad has completed graduate work at Northwestern University, and Berlin, Warsaw and Cracow Universities in Europe. His talk in Savannah is being sponsored by the Woman's Auxiliary to the Medical Association of Georgia.

An address entitled "A Good State Journal", concerning the medical journal publication field will be given before the Editorial Board of the *Journal of the Medical Association of Georgia* by the distinguished editor of the *Journal of the Florida Medical Association*, SHALER A. RICHARDSON, M.D. Dr. Richardson, a graduate of Vanderbilt University School of Medicine, Nashville, 1913, is now Chief of Ophthalmology at Duval County Hospital and resides in Jacksonville, Florida. Serving as editor of the Florida Medical Association Journal, Dr. Richardson will comment on problems directly concerning the Editorial Board, drawing on his vast field of experience in his present capacity.

Notices

Registration

1. All members must register and wear badges to be admitted to the Scientific Sessions of the Association. The Registration Desk for this purpose is in the South Lobby, facing the main entrance of the Gold Room, Hotel DeSoto.

2. Delegates should present written credentials for admittance to the House of Delegates. Proceedings of the House of Delegates on Sunday, May 10, will be held in the Gold Room, Hotel DeSoto; and on Tuesday, May 12 in the Auditorium of the Georgia Medical Society Hall, 612 Drayton St.

Announcements

The Association Golf Tournament will be held at the Savannah Golf Club during Sunday, Monday and through Tuesday noon; May 10-12. Specific details can be obtained from the Golf Chairman.

Special bus service will be provided for members and their wives attending the Social Hour and Smorgasbord at the Oglethorpe Hotel, Wilmington Island, Savannah, on Sunday evening, 6:00 p.m., May 10.

Register at the Technical Exhibits

Of course you'll want to visit *all* the Technical Exhibits and it is very important for you to register at each one of them when you chat with the exhibitor. These exhibitors are actively supporting *your* Annual Session and they contribute greatly to its success. Again, as a reminder, please visit their exhibits and register with them.

Your Social Events Calendar

Slated for the social side of the Annual Session are the following main events:

(1) Sunday evening, May 10, at 6:00 p.m. to 9:00 p.m., a gala Social Hour and Smorgasbord for Members and their Wives (Tickets Required. This will be held in the General Oglethorpe Hotel, Wilmington Island.

(2) Tuesday evening, May 12, at 7:00 p.m., you won't want to miss the President's Dinner (Subscription). It will be held in the Grand Ballroom, Hotel DeSoto.

(3) If it's Golf that you're looking forward to, there will be daily tournaments. There are Tourney prizes—and the facilities for breaking par are topnotch with a fast, well kept course to master. Tee-off times will be announced and posted.

(4) Alumni Dinners. Surely you want to get together with the grads and chat about the early school days. It's Alma Mater time when old classmates meet and eat. Monday night, May 11, at 7:00 p.m. the following Alumni dinners are slated: Medical College of Georgia; Emory University of Medicine; University of Virginia Department of Medicine; and Tulane University of Louisiana School of Medicine.

They're all going

to the CONVENTION

Join the throng

and say

"SEE YOU IN SAVANNAH"

at the . . .

One Hundred and Third Annual Session

Medical Association of Georgia

Hotel DeSoto, May 10-13, 1953

THE PROGRAM

The following papers are announced to be read before the scientific sessions. The order here is not necessarily the order that will be followed in the Official Program, and minor changes may be required by conditions beyond the control of the committee. Be sure to check your Official Program for final details.

THOMAS L. ROSS, Chairman
H. ANSLEY SEAMAN
C. F. HOLTON
DAVID HENRY POER
CHARLES L. PRINCE

Sunday Morning, May 10

9:00 REGISTRATION OF DELEGATES:
South Lobby, Hotel DeSoto (adjoining Gold Room).

FINAL MEETING OF COUNCIL:
Habersham Room, Hotel DeSoto.

10:00 MEETING, HOUSE OF DELEGATES:
Gold Room, Hotel DeSoto.

Sunday Afternoon, May 10

1:00 LUNCH.

2:00 MEETING, HOUSE OF DELEGATES:
Gold Room, Hotel DeSoto.
"Today's Challenge to Medicine", Louis H. Bauer, President American Medical Association.

"The National Legislative Outlook", Julian P. Price, Member, AMA Committee on Legislation, Florence, S. C.

2:30 FILM READING SESSION:
Georgia Radiological Society.
Chatham Room, Hotel DeSoto.

3:00 ADVANCE REGISTRATION OF MEMBERS:
South Lobby, Hotel DeSoto.

3:45 JOINT MEMORIAL SERVICE:
Grand Ballroom, Hotel DeSoto.
Presiding: C. F. Holton, President, Savannah.
Invocation: The Rev. Ernest Risley, Minister, St. John's Episcopal Church, Savannah.

"It Singeth Low in Every Heart" (Hiles), Miss Edith Bennett, vocalist; Mr. Dwight J. Bruce, accompanist.

Memorial Address, The Rev. Ernest Risley.
In Memoriam: Albert J. Kelley.

"The Lord's Prayer" (Malotte), Miss Bennett and Mr. Bruce.
Benediction.

4:30 OPEN PUBLIC MEETING:
(MAG Auxiliary Sponsorship).
Grand Ballroom, Hotel DeSoto.
Presiding: Mrs. Ralph Fowler, Auxiliary President, Marietta.

"Are We Educating or Indoctrinating Our Children?", Mr. Arthur L. Conrad, President, The Heritage Foundation, Inc., Chicago.

Sunday Night, May 10

6:00 SOCIAL HOUR AND SMORGASBORD FOR OFFICERS, DELEGATES AND GUESTS (including wives)

General Oglethorpe Hotel, Wilmington Island, Savannah.

(Tickets Required, Special bus service from the Hotel DeSoto to be furnished).

Monday Morning, May 11

8:30 OPENING SESSION
Grand Ballroom, Hotel DeSoto.
Presiding: C. F. Holton, President, Savannah.

INVOCATION:

The Rev. Ernest Risley, Minister of St. John's Episcopal Church, Savannah.

ADDRESSES OF WELCOME:

The Hon. Olin F. Fulmer, Mayor of Savannah. Howard J. Morrison, President, Georgia Medical Society, Savannah.

SPECIAL ANNOUNCEMENTS:

Monroe J. Epting, Chairman, Committee on Local Arrangements, Savannah.

9:00 PANEL DISCUSSION:
Gold Room, DeSoto Hotel.

"The Program of Vocational Rehabilitation in Georgia", Carl C. Aven, Atlanta, Moderator. Discussors: Mr. A. P. Jarrell, Assistant Director, Division of Vocational Rehabilitation, Atlanta; Thomas P. Goodwyn, Atlanta; Julian K. Quattlebaum, Savannah; Lester Harbin, Rome; Milford B. Hatcher, Macon; Braswell E. Collins, Waycross.

9:00 CLINICAL SESSION:
Grand Ballroom, Hotel DeSoto.
Presiding: H. L. Cheves, Union Point.

SYMPOSIUM:

"Neuropsychiatry in General Practice."

"Present Facilities and Future Needs in Psychiatry in Georgia", Raymond S. Crispell, Atlanta. Discussors: T. G. Peacock, Milledgeville; J. R. S. Mays, Macon.

9:20 "Drug Therapy in Senile and Arteriosclerotic Psychoses", H. Dawson Allen, Jr., Milledgeville. Discussors: Lawrence F. Woolley, Atlanta; Harry R. Lipton, Atlanta.

9:40 "A Study of Squints at Gracewood, Georgia Training School for Mental Defectives",

Henry R. Perkins, Augusta. Discussors: J. Victor Roule, Augusta; Norman B. Pursley, Gracewood; F. Phinizy Calhoun, Jr., Atlanta.

10:00 "Some Methods That Have Proved Useful in the Beginning of Psychotherapy With Neurotic Patients", John Warkentin, Atlanta. Discussors: Rives C. Chalmers, Atlanta; Leonard T. Maholick, Columbus.

10:30 INTERMISSION TO VIEW EXHIBITS.

11:00 CLINICAL SESSION:

Grand Ballroom, Hotel DeSoto.

Presiding: H. Dawson Allen, Milledgeville.

11:00 "Care of the Premature Infant", Heyworth N. Sanford, Chicago.

11:20 "Gastrointestinal Bleeding", Robert D. Moreton, Ft. Worth, Texas.

11:40 "Acute Cholecystitis", Alton Ochsner, New Orleans, La.

12:00 PRESIDENT'S ADDRESS:

C. F. Holton, Savannah.

Presentation of President's Key and Certificate of Appreciation.

Presentation of Fifty-Year Certificates: Mark S. Dougherty, Jr., Chairman, Committee on Awards, Atlanta.

Nomination of Officers: President-Elect, First Vice-President, Second Vice-President, AMA Delegate and Alternate Delegate, Councilors: 5th, 6th, 7th, 8th.

Monday Afternoon, May 11

1:00 LUNCHEONS:

Georgia Pediatrics Society

Colonial Room, Hotel DeSoto.

Georgia Radiological Society

Chatham Room, Hotel DeSoto.

Georgia Urological Society

Oglethorpe Club, 450 Bull St.

Georgia Chapter, American College of Surgeons.

Sapphire Room, Hotel DeSoto.

Georgia Society of Ophthalmology and Otolaryngology.

Habersham Room, Hotel DeSoto.

2:00 SECTION MEETINGS:

4:30 *Hotel DeSoto.*

2:00 GENERAL SURGERY:

Sapphire Room, Hotel DeSoto.

Presiding: Thomas Harrold, Macon, Chairman.

"The Early Diagnosis and Treatment of Cancer of the Stomach", Alton Ochsner, New Orleans.

"Congenital Reduplication of the Stomach", John T. Akin, Atlanta. Discussors: J. H. Sherman, Augusta; Lon W. Grove, Atlanta.

"Strictures of the Common Bile Duct", James L. Caldwell, Macon. Discussors: Lester Harbin, Rome; Thomas W. Goodwin, Augusta.

"The Treatment of Gastroduodenal Hemorrhage with Coagulating Agents", John M. McClure, Jr., Atlanta. Discussors: A. G. Little, Jr., Valdosta; David F. James, Atlanta.

"Improved Technique in Hemorrhoidectomy with Discussion of Postoperative Discomfort", Richard A. Krause, Augusta. Discussors: James C. Thoroughman, Augusta; Edgar Boling, Atlanta.

2:00 PEDIATRICS:

Colonial Room.

Presiding: John A. Simpson, Athens.

"Some Problems in the Care of the New-born", Heyworth N. Sanford, Chicago.

"Adjustment Problems With Children", Thomas E. Bailey, Augusta. Discussors: Howard J. Morrison, Savannah.

"The Pediatrician as Family Advisor", William H. Kiser, Jr., Atlanta.

"Surgical Correction of Achalasia of the Esophagus in Infants", Richard King, Atlanta. Discussors: M. Hines Roberts, Atlanta; C. Hall Farmer, Macon.

2:00 RADIOLOGY:

Chatham Room.

Presiding: Robert M. Tankesley, Atlanta.

"Roentgenologic Examination of the Colon", Robert D. Moreton, Fort Worth, Texas.

Roentgenogram Demonstration.

3:30 Symposium on Radiological Procedures in General Practice.

"Radiologic Investigation of Obstructing Lesions of the Colon", Ted F. Leigh, J. W. Rogers, Jr., Brit B. Gay, Jr., and Jose Bonmati, all of Emory University. Discussors: J. D. Martin, Jr., Emory University; Stephen W. Brown, Augusta.

"Roentgenographic Diagnosis of Gall Bladder Disease", J. J. Collins, Thomasville. Discussors: Palmer Holmes, Augusta; Robert C. Pendergrass, Americus.

"Roentgen Treatment of Certain Benign Conditions", Bert H. Malone, Brunswick. Discussors: Frank G. Eldridge, Valdosta; Neal F. Yeomans, Waycross.

2:00 UROLOGY:

Oglethorpe Club, 450 Bull St.

Presiding: Reese C. Coleman, Atlanta.

Pyleographic Clinic.

Monday Night, May 11

7:00 ALUMNI DINNERS:

Medical College of Georgia; T. A. Peterson, Savannah, Chairman. Speaker: The Hon. Herman E. Talmadge, Governor, State of Georgia.

Grand Ballroom, Hotel DeSoto.

Emory University School of Medicine. D. L. Brawner, Savannah Chairman. Address by Eugene B. Ferris, Jr.
Gold Room, Hotel DeSoto.

University of Virginia Department of Medicine, (Location and speaker to be announced). Richard L. Schley, Jr., Savannah, Chairman.

Tulane University of Louisiana School of Medicine, (Location and speaker to be announced). Harry Evan Rollings, Savannah, Chairman.

7:30 DINNER MEETING:

Oglethorpe Club.

Editorial Board, The Journal of the Medical Association of Georgia. Charles L. Prince, Savannah, Chairman.

"A Good State Journal", Shaler Richardson, Editor, *The Journal of the Florida Medical Association*, Jacksonville.

10:00 "ALL MY BABIES":

Gold Room, Hotel DeSoto.

(A film, restricted for showing to physicians, special booking of which is sponsored by the Woman's Auxiliary to the Medical Association of Georgia.)

Tuesday Morning, May 12

9:00 SYMPOSIUM ON GASTROENTEROLOGY:

Grand Ballroom, Hotel DeSoto.

Moderator: E. Van Buren, Atlanta.

9:00 "Reasons for Failure in the Therapy of Peptic Ulcer Patients", Charles W. Hock, Augusta.

9:20 "Further Observations on Use of Vagotomy for Duodenal Ulcer", Charles H. Richardson, Jr., Macon.

9:40 "The Diagnosis of Carcinoma of the Pancreas", Henry H. Tift, Macon. Discussors: J. Benham Stewart, Macon; T. R. Freeman, Savannah. W. Derrell Hazlehurst, Macon; John S. Atwater, Atlanta; E. L. Bosworth, Rome; George Walker, Griffin.

10:00 "The Relationship of Nutritional and Soil Deficiencies", W. W. Turner, Nashville. Discussors: T. F. Sellers, Atlanta; Mary Spiers, Ph.D., Experiment.

9:00 SYMPOSIUM ON ORTHOPEDICS AND TRAUMA:

Gold Room, Hotel DeSoto.

Moderator: Sage Harper, Douglas.

9:00 "Irreducible Supracondylar Fractures in Children: Treatment by Intramedullary Transfixion", Charles M. Henry, Clarkesville. Discussors: C. G. Henry, Augusta; R. P. Kelly, Jr., Emory University.

9:20 "The Ruptured Intervertebral Disk Syndrome", Louis A. Hazouri, Columbus. Discussors: Edgar F. Fincher, Jr., Emory University; L. O. J. Manganiello, Augusta.

9:40 "Osteitis Condensans Ilii", David Robinson and W. U. Clary, Savannah. Discussors: Peter B. Wright, Augusta; Ernest G. Edwards, Savannah.

10:00 SYMPOSIUM ON VASCULAR SURGERY:

Moderator: W. Bruce Schaefer, Toccoa.

10:00 Surgery in Some Vascular Emergency Conditions", Robert B. Gottschalk, Savannah. Discussors: Julian K. Quattlebaum, Savannah; Daniel C. Elkin, Emory University.

10:20 "Successful Anastomosis of Common and Internal Carotid Arteries Following Resection of Defective Portion", P. C. Shea, Jr., Atlanta. Discussors: David Henry Poer, Atlanta; William G. Whitaker, Atlanta.

10:40 INTERMISSION TO VIEW EXHIBITS.

11:00 GENERAL SESSION:

Grand Ballroom, Hotel DeSoto.

Presiding: D. Lloyd Wood, Dalton.

11:00 "Dysfunction of the Colon"—Lemuel C. McGee, Wilmington, Del.

11:20 "Our Aging Population", J. P. Sanders, Shreveport, La.

11:40 "General Aspects of Leptospirosis Infection", Walter H. Sheldon, Emory University.

12:00 ABNER W. CALHOUN LECTURE:

Daniel C. Elkin, Chairman, presiding.

"Some Recent Advances in Hematology", Cyrus C. Sturgis, Ann Arbor, Michigan.

Tuesday Afternoon, May 12

1:00 LUNCHEONS:

Georgia Academy of General Practice.
Colonial Room, Hotel DeSoto.

"The Renaissance of Medicine During the Past Generation", J. P. Sanders, Shreveport, La.

Georgia Industrial Surgeons Association.
Sapphire Room, Hotel DeSoto.

Georgia Association of Pathologists.
Habersham Room, Hotel DeSoto.

Georgia State Society of Anesthesiologists.
(Location to be announced).

Georgia Orthopedic Society.
(Location to be announced).

Georgia Chapter, American Medical Women's Association.
Chatham Room, Hotel DeSoto.

2:00 SECTION MEETINGS:

Hotel DeSoto.

2:00 **PATHOLOGY:**
Habersham Room.
 Presiding: Darrell Ayer, Atlanta.
 "Leptospiral Infection", Walter H. Sheldon,
 Emory University.

2:00 **INDUSTRIAL SURGERY AND MEDICINE:**
Sapphire Room.
 Presiding: Joseph C. Read, Atlanta.
 "Operational Responsibilities of a Medical
 Department in Industry", Lemuel C. Mc-
 Gee, Wilmington, Del.

SYMPOSIUM ON BURNS:

Moderator: Ben R. Thebaut, Atlanta.
 "The Mass Treatment of Burns in Atomic
 Warfare"—Joseph R. Shaeffer, Col., MC,
 Washington, D. C.
 "The Early Treatment of Burns", George
 S. Tootle, Atlanta.
 "The Late Treatment of the Severely Burned
 Patient", S. A. Roddenberry, Columbus.
 Discussors: Milford B. Hatcher, Macon;
 Kirk Shepard, Thomasville; Edward S.
 Marks, Marietta; John R. Lewis, Atlanta.
 "Treatment of Industrial Eye Injuries", Cyrus
 W. Stoner, Atlanta. Discussor: Braswell
 E. Collins, Waycross.
 "Recent Progress in the Management of Pa-
 tients With Intervertebral Disk Lesions",
 Exum Walker, Atlanta. Discussors: C. F.
 Holton, Savannah; Robert F. Mabon, At-
 lanta.

3:00 **HOUSE OF DELEGATES:**
*Auditorium, Georgia Medical Society Hall,
 612 Drayton Street.*

Tuesday Night, May 12

5:30 **RECEPTION FOR MAG MEMBERS AND
 WIVES:**
Gold Room, Hotel DeSoto.
 Hosts, Central of Georgia Railroad Company.

7:00 **PRESIDENT'S DINNER: (Subscription)**
Grand Ballroom, Hotel DeSoto (Subscription)
 Toastmaster: James C. Metts, Savannah.
 "Facing the Future", The Hon. Robert Bryan
 Carr, Presiding Judge, Alabama Court of
 Appeals, Montgomery, Alabama.
 Award of Golf Prizes, John G. Sharpley,
 Savannah.
 Dancing. Jacobson's Orchestra, Savannah.

Wednesday Morning, May 13

7:30 **MAG COUNCIL BREAKFAST AND MEETING:**
Habersham Room, Hotel DeSoto.

9:00 **PANEL DISCUSSION:**
Gold Room, Hotel DeSoto.
 "Insurance Plans and Problems in Georgia."

Moderator: Mr. H. B. Coolidge, Savannah,
 Director, Physicians' Service Association
 of Savannah. Discussors: W. S. Dorough,
 Atlanta; W. F. Pomeroy, Waycross; John
 Elliott, Savannah; J. Z. McDaniel, Albany.

9:00 **CLINICAL SESSION:**
Grand Ballroom, Hotel DeSoto.
 Presiding: Rudolph F. Bell, Thomasville.

SYMPOSIUM:

"Urology in General Practice."

9:00 "Undiagnosed, Gross Upper Urinary Tract
 Bleeding", Alex L. Finkle, Charles L.
 Prince and Peter L. Scardino, all of Sa-
 vannah.

9:20 "Management of Urinary Calculi", James
 H. Semans, Atlanta. Discussors: Peter L.
 Scardino, Savannah; Duncan Shepard, At-
 lanta, Wallace L. Bazemore, Macon; W.
 H. Bennett, Atlanta.

9:40 "Psychiatric Sequelae of Severe Head In-
 juries", Joseph D. McElroy, Atlanta. Dis-
 cussors: Richard B. Wilson, Atlanta;
 Joseph S. Skobba, Atlanta.

10:00 "Pre- and Postoperative Management, One
 Stage Total Adrenalectomy: Report of
 Four Cases", Thomas A. McGoldrick, Jr.,
 Savannah. Discussors: William F. Good-
 year, Atlanta; W. E. Barfield, Augusta.

10:30 **INTERMISSION TO VIEW EXHIBITS.**

11:00 **CLINICAL SESSION:**
Grand Ballroom, Hotel DeSoto.
 Presiding: James H. Semans, Atlanta.

11:00 "Controversial Aspects of Late Pregnancy
 Bleeding", Duncan E. Reid, Boston, Mass.

11:20 "What to Expect of the Photofluorogram",
 Sydney Jacobs, New Orleans, Louisiana.

11:40 "Progress in Georgia Civil Defense Health
 Services", Edgar M. Dunstan, Atlanta.

12:00 **GENERAL MEETING MAG MEMBERS:**
Grand Ballroom, Hotel DeSoto.
 Presiding: C. F. Holton, Savannah.

Announcements:

"The Georgia Post Mortem Examination
 Act: An Explanation", Warren B. Mat-
 thews, Atlanta.

Results of Officers Election.

Vote on Amendments to MAG Constitu-
 tion and By-Laws.

New Council Organization Meeting.

Wednesday Afternoon, May 13

1:00 **LUNCHEONS:**
 Georgia State Obstetrical and Gynecological
 Society.

Gold Room, Hotel DeSoto.

Georgia Chapter, American College of Chest
 Physicians and Georgia Trudeau Society

(Combined Luncheon).
Chatham Room, Hotel DeSoto.

Georgia Chapter, American College of Physicians (organizational luncheon).
Sapphire Room, Hotel DeSoto.

2:00 SECTION MEETINGS:
Hotel DeSoto.

2:00 OBSTETRICS AND GYNECOLOGY:
Gold Room.

Presiding: George A. Williams, Atlanta.

"Management of the Diabetic Patient in Pregnancy", Duncan E. Reid, Boston.

"Pelvic Evisceration for Advanced Cancer of the Cervix", Sam A. Wilkins, Jr., Emory University. Discussors: John H. Ridley, Atlanta; G. P. McInnes, Augusta.

"Loss of Life Occurring in Relation to the Reproductive Process", Helen W. Bellhouse, Atlanta, and H. F. Sharpley, Jr., Savannah. Discussors: Robert B. Martin, Cuthbert; E. D. Colvin, Atlanta; R. L. Johnson, Douglas, C. M. Mulherin, Augusta; Fred H. Simonton, Chickamauga (Members, Committee on Material Welfare).

2:00 INTERNAL MEDICINE:
Sapphire Room.

Presiding: Thomas L. Ross, Macon.

"Hypersensitivity Reaction to Procaine Penicillin . . . Anaphylactic Shock; Acute Ulcerative Cystitis and Acute Ulcerative Colitis", Robert L. Whipple, Jr., Atlanta. Discussors: William F. Friedewald, Atlanta; J. H. Hilsman, Atlanta.

"Hypersplenism with Pancytopenia: Report of a Case", Mark S. Dougherty, Jr., Atlanta. Discussors: Darrel Ayer, Atlanta; Fenwick T. Nichols, Jr., Savannah.

"Coronary Insufficiency or Failure", Lamont Henry, Atlanta. Discussors: Thomas L. Ross, Jr., Macon; C. Purcell Roberts, Atlanta.

Newer Advances in Chemotherapy of Lymphoma", Tully T. Blalock, Atlanta. Discussors: George Hutto, Columbus, Milton H. Freedman, Atlanta.

"Continuous Treatment of the Nephrotic Syndrome in Children with ACTH", Arthur J. Merrill, Atlanta. Discussors: Roger W. Dickson, Atlanta; Don F. Cathcart, Atlanta; James P. Hanner, Atlanta; T. Bolling Gay, Atlanta.

2:00 CHEST:

Chatham Room.

Presiding: John L. Elliott, Savannah.

"Diabetes and Tuberculosis", Sydney Jacobs, New Orleans, La.

"Pneumoconiosis in Soft Coal Workers", Louis L. Friedman, Birmingham, Alabama.

"The Management of Thoracic Trauma", James L. Alexander, Savannah.

"Present Status of the Isoniazid Therapy Study Program", H. E. Crow, Rome. Discussors: Rufus F. Payne, Augusta; John L. Elliott, Savannah.

"The Medical Profession—Responsibility to Tuberculosis Patients: A Public Health Viewpoint", H. C. Schenck, Atlanta. Discussors: C. C. Aven, Atlanta; Clarence W. Mills, Atlanta.

"The Therapeutic Response of Surgical Resection in Pulmonary Tuberculosis: A Study of One Hundred Cases", W. E. Van Fleit, Emory University. Discussors: Robert G. Ellison, Augusta; Samuel E. Patton, Macon.

"The Management of Obstruction to the Outflow Tract of the Right Ventricle", William A. Hopkins and Osler A. Abbott, Emory University. Discussors: Robert C. Major, Augusta; Harry T. Harper, Augusta.

"Technique of Operation for Pulmonic Stenosis" (A Film), Hopkins and Abbott.

IN MEMORIAM

BAIRD, Noah W., Atlanta, June 24, 1952
BARTON, John J., Dublin, July 8, 1952, age 82
BRAMBLETT, R. H., Cumming, December 16, 1952, age 66
BREWER, Asbury, Tunnel Hill, April 24, 1952, age 79
BROWN, Stewart Dixon, Royston, May 30, 1952, age 71
CHANDLER, William Vance, Baldwin, August 10, 1952, age 85
CHAPMAN, William Allen, Cedartown, November 30, 1952, age 87
CHEEK, Pratt, Sr., Gainesville, August 26, 1952, age 67
COBB, Tyrus Raymond, Jr., Dublin, September 9, 1952, age 42
COLSAN, Dell Cassidy, Glenwood, May 16, 1952, age 70
DEAL, Ben A., Statesboro, September 24, 1952, age 68
DOSTER, Henry William, Augusta, December 23, 1952, age 86
FLOURNOY, Harrison Clinton, Warwick, May 4, 1952, age 65

FREDERICK, Donald B., Marshallville, June 14, 1952, age 73
GARNER, James Ryan, Atlanta, July 16, 1952, age 75
GILES, Jackson T., Valdosta, November 4, 1952, age 34
GREENE, Edgar Hill, Atlanta, May 30, 1952, age 63
HAIR, William B., Summerville, September 5, 1952, age 60
HATTAWAY, John Calvin, Jr., Edison, November 29, 1952, age 52
HAYS, W. C., Colquitt, September 14, 1952, age 72
HOLLOMAN, Alfred Leon, Savannah, October 20, 1952, age 38
HUMPHREY, Thomas S., Springfield, August 20, 1952, age 77
HUMPHREYS, Alexander S., Brooks County, September 4, 1952, age 86
HUNT, G. C. D., Cordele, November 27, 1952, age 82
HUTCHINSON, Lee Roy, Adel, June 1, 1952, age 61
JONES, Henry, Coolidge, April 30, 1952, age 82

LANIER, John Edward, Colquitt County, January 25, 1953, age 80
 LANIER, John Roy, Swainsboro, July 7, 1952, age 51
 LEE, Lawrence, Sr., Savannah, January 11, 1953, age 72
 LINDLEY, F. P., Powder Springs, January 1, 1953, age 62
 MANGET, James D., Atlanta, August 16, 1952, age 70
 McGEE, Harry H., Savannah, age 51
 McGOWAN, Hugh Strong, Cartersville, December 19, 1952, age 71
 MILLER, Harold Applegate, Augusta, September 22, 1952, age 78
 MOBLEY, H. A., Vienna, January 2, 1953, age 86

OWENSBY, Newdigate Moreland, Atlanta, August 10, 1952, age 69
 PETTIT, James K., Atlanta, May 22, 1952, age 63
 RIDLEY, Frank M., Jr., LaGrange, January 29, 1953, age 69
 SAGGUS, John Gordon, Harlem, November 24, 1952, age 64
 SHANKS, Edgar DeWitt, Atlanta, February 12, 1953, age 63
 SMITH, Racy Hawkins, Lincolnton, May 4, 1952
 SPRUELL, T. M., Carroll County, July 25, 1952, age 84
 SUMNER, Gordon S., Worth County, March 13, 1953, age 68
 TYRE, J. Lawson, Screven County, October 4, 1952, age 66
 VEALE, E. O., Arnoldsville, March 10, 1953, age 77
 VINTON, Luther Mansfield, Atlanta, July 2, 1952, age 63
 VOGT, Elkin, Lithonia, May 5, 1952, age 49
 WILKINSON, William Lee, Bainbridge, May 24, 1952, age 64

Georgia Physicians Who Have Practiced Medicine Fifty Years

This list does not contain the names of all Georgia physicians who have practiced medicine 50 years or more. This list records the class of 1953 *only*.

Abercrombie, Thomas F.; Atlanta
 Bagley, David A.; Austell
 Denton, John F.; Atlanta
 Ezzard, W. P.; Lawrenceville
 Fort, Mannie A.; Bainbridge
 Hall, Thomas H.; Macon
 McCrackin, Horace C.; Baxley
 Nelson, Richard M.; Atlanta (Florida)
 Tanner, William H.; Newnan
 Wallis, James R.; Lovejoy
 Wilson Lloyd E.; Bowden

Scientific Exhibits

Rotunda, Hotel DeSoto

1. "Legal Medicine", Georgia Association of Pathologists.
2. "The Maternal Care Problem in Your County." Division of Maternal and Child Health, Georgia Department of Public Health and Maternal Care Committee, Medical Association of Georgia, Atlanta.
3. "Malignant Lymphoma of the Stomach", I. R. Berger, M.D., Atlanta.
4. "Articles Manufactured by the Georgia Factory for the Blind", Vaughn Terrell, Superintendent, Georgia Factory for the Blind, Bainbridge.
5. "Bleeding from the Gastrointestinal Tract", Charles W. Hock, M.D., Medical College of Georgia, Augusta.
6. "Plastic Surgery of the Nose", John R. Lewis, Jr., M.D., Atlanta.
7. "Cancer of the Cervix", American Cancer Society, Inc., Georgia Division, Atlanta.
8. "The New Chatham County Memorial Hospital", (Abreau and Robeson, Architects).
9. "The American Medical Education Foundation", Committee on AMEF of the Medical Association of Georgia.
10. "Advances in the Treatment of Spina Bifida", Robert A. Sears, M.D., William R. Chambers, M.D. and Exum Walker, M.D., The Neuroclinic, Atlanta.
11. "Vertical Flap Ureteropelvioplasty", Peter L. Scardino, M.D., Savannah.

Technical Exhibits

Georgian Room and Lobby, Hotel DeSoto

Booth:

- 1 William P. Poythress & Company, Inc.
Richmond, Virginia
- 2 Hoffman-La Roche, Inc.
Roche Park, Nutley 10, New Jersey
- 3 Philip Morris & Company, Ltd., Inc.
100 Park Avenue, New York 17, New York
- 4 Ciba Pharmaceutical Products, Inc.
Lafayette Park, Summit, New Jersey
- 5 Lantien Medical Laboratories, Inc.
2020 Glenwood Street, Evanston, Illinois
- 6 Baker Laboratories, Inc.
4614 Prospect Avenue, Cleveland 3, Ohio

- 7 Sharp & Dohme, Inc.
640 North Broad St., Philadelphia 1, Pennsylvania
- 8 Doho Chemical Corporation
100 Varick Street, New York 13, New York
- 9 A. S. Aloe Company
492 Peachtree Street, N. E., Atlanta, Georgia
- 10 Marks Surgical Supplies, Inc.
1429 Harper Street, Augusta, Georgia
- 11 VanPelt & Brown, Inc.
1322 E. Main St., Richmond, Virginia
- 12 Hart Drug Corporation
25 N. E. Twenty-Fifth Street, Miami 30, Florida
- 13 M & R Laboratories, Inc. (Similac)
585 Cleveland Avenue, Columbus 16, Ohio
- 14 American Hospital Supply Corporation
Chamblee, Georgia
- 15 Tattle-Toes
Chesterfield, Missouri
- 16 American Surgical Supply Company
489 Peachtree Street, N. E., Atlanta, Georgia
- 17 Pet Milk Company
1401 Arcade Building, St. Louis, Missouri
- 18 Ames Company, Inc.
Elkhart, Indiana
- 19 Ayerst, McKenna & Harrison, Ltd.
22 East 40th Street, New York 16, New York
- 20 Brown and Williamson Tobacco Corp. (Kool Cigarettes) 600 W. Hill St., Louisville, Kentucky
- 21 Winthrop-Stearns, Inc.
1450 Broadway, New York 18, New York
- 22 Travenol Laboratories, Inc.
Morton Grove, Illinois
- 23 Wyeth Laboratories
1401 Walnut Street, Philadelphia 2, Pennsylvania
- 24 The Stuart Company
35 E. Wacker Drive, Chicago 1, Illinois
- 25 Chicago Pharmacal Company
5547 N. Ravenswood Ave., Chicago 40, Illinois
- 26 Sandoz Pharmaceuticals
68 Charlton Street, New York 14, New York
- 27 Eli Lilly and Company
Indianapolis 6, Indiana
- 28 Parke, Davis & Company
Detroit 32, Michigan
- 29 A. H. Robins Company, Inc.
1407 Cummings Drive, Richmond, Virginia
- 30 Surgical Selling Company
139 Forrest Avenue, N. E., Atlanta 3, Georgia
- 31 Tablerock Laboratories, Inc.
Greenville, South Carolina
- 32 Chas. Pfizer & Co., Inc.
630 Flushing Avenue, Brooklyn 6, New York
- 33 C. B. Fleet Co., Inc.
921 Commerce Street, Lynchburg, Virginia
- 34 Ortho Pharmaceutical Corporation
Raritan, New Jersey
- 35 S & H X-Ray Company
501 Peachtree Street, N. E., Atlanta, Georgia
- 36 Wachtel's Physician Supply Co.
406 Bull Street, Savannah, Georgia
- 37 E. R. Squibb & Sons
745 Fifth Avenue, New York 22, New York

- 38 General Electric Company, X-Ray Department
1383 Spring Street, N. W., Atlanta, Georgia
- 39 National Life Insurance Company of Vermont
Montpelier, Vermont
- 40 Brown and Williamson Tobacco Corporation
(Viceroy Cigarettes) 600 Hill St., Louisville, Kentucky

- 41 Coca-Cola Company
Atlanta, Georgia
- 42 Organon, Inc.
Orange, New Jersey
- 43 The Lanier Company
155 Spring Street, N. W., Atlanta, Georgia

THE WOMAN'S AUXILIARY

28th Annual Convention

Hotel DeSoto, Savannah

May 10-13, 1953

PRESIDENT'S INVITATION

Marietta, Georgia
April 1, 1953

To members of the Auxiliary to the Medical Association of Georgia, and to those physicians' wives who are not members:

You are cordially invited to attend the Twenty-eighth annual meeting of the Woman's Auxiliary to the Medical Association of Georgia in Savannah May 10-13. Our meetings will be held in the S.S.S. Club, across the street from our headquarters at the DeSoto Hotel.

Chatham County, our hostess auxiliary has made some most delightful plans for your entertainment. Read the program on the following pages and let's all get together in Savannah!

Sincerely,

MRS. RALPH W. FOWLER, President
Woman's Auxiliary to the Medical
Association of Georgia



MRS. RALPH W. FOWLER, President

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta

Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta,
Temporary Chairman.

1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta

1926—Albany—Mrs. William H. Myers, Savannah

1927—Athens—Mrs. C. W. Roberts, Atlanta

1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore,
Gaffney, S. C.)

1929—Macon—Mrs. Charles C. Hinton, Macon

1930—Augusta—Mrs. Marion T. Benson, Atlanta

1931—Macon—Mrs. Charles C. Harrold, Macon

1932—Savannah—Mrs. Ralston Lattimore, Savannah

1933—Macon—Mrs. S. T. R. Revell, Louisville

1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)

1935—Atlanta—Mrs. J. E. Penland, Waycross

1936—Savannah—Mrs. Ernest R. Harris, Winder

1937—Macon—Mrs. W. R. Dancy, Savannah

1938—Augusta—Mrs. Ralph Chaney, Augusta

1939—Atlanta—Mrs. Warren A. Coleman, Eastman

1940—Savannah—Mrs. Eustace A. Allen, Atlanta

1941—Macon—Mrs. W. G. Banister, Rome

1942—Augusta—Mrs. Lee Howard, Savannah

1943—Atlanta—Mrs. J. Lon King, Macon

1944—Savannah—Mrs. Olin S. Cofer, Atlanta

1945—No convention

1946—Macon—Mrs. W. T. Randolph, Winder

1947—Augusta—Mrs. Bruce Schaefer, Toccoa

1948—Atlanta—Mrs. W. G. Elliott, Cuthbert

1949—Savannah—Mrs. S. A. Anderson, Atlanta

1950—Macon—Mrs. J. Harry Rogers, Atlanta

1951—Augusta—Mrs. Lehman W. Williams, Savannah

1952—Atlanta—Mrs. J. R. S. Mays, Macon

PROGRAM
Twenty-Eighth Annual Convention
of the
Woman's Auxiliary
to the
Medical Association of Georgia
S.S.S. Club
346 Bull Street, Savannah
May 10, 11, 12, 13, 1953

Officers and Committees

<i>President</i> —Mrs. Ralph W. Fowler.....	Marietta
<i>President-Elect</i> —Mrs. Leo Smith.....	Waycross
<i>First Vice-President</i> —Mrs. Murdock Euen.....	Atlanta
<i>Second Vice-President</i> —Mrs. R. C. McGahee.....	Augusta
<i>Third Vice-President</i> —Mrs. W. K. Jordan.....	Macon
<i>Recording Secretary</i> —Mrs. Virgil Williams.....	Griffin
<i>Corresponding Secretary</i> —Mrs. John F. Busch, Jr.....	Marietta
<i>Treasurer</i> —Mrs. M. T. Edgerton.....	Atlanta
<i>Historian</i> —Mrs. T. A. Peterson.....	Savannah
<i>Parliamentarian</i> —Mrs. W. Bruce Schaefer.....	Toccoa

Advisory Committee

Dr. Ralph Chaney, <i>Chairman</i>	Augusta
Dr. Enoch Callaway.....	LaGrange
Dr. A. M. Phillips.....	Macon
Dr. W. F. Reavis.....	Waycross

Standing Committee Chairmen
1952-1953

<i>Achievement Award</i> —Mrs. Ralph Chaney.....	Augusta
<i>Archives</i> —Mrs. C. W. Roberts.....	Atlanta
<i>Budget</i> —Mrs. W. G. Elliott.....	Cuthbert
<i>Bulletin</i> —Mrs. D. Lloyd Wood.....	Dalton
<i>Doctor's Day</i> —Mrs. Lehman W. Williams.....	Savannah
<i>Editorial</i> —Mrs. Ben H. Clifton.....	Atlanta
<i>Scrapbook Award</i> —Mrs. W. P. Stoner.....	Sylvester
<i>Legislation</i> —Mrs. Everett A. Bancker.....	Atlanta
<i>Public Relations</i> —Mrs. Walker Curtis.....	College Park
<i>Research in Romance of Medicine</i> —Mrs. Truman Whitfield.....	Dalton
<i>Revisions</i> —Mrs. Lee Howard.....	Savannah
<i>Student Loan Fund</i> —Mrs. Shelley Davis.....	Atlanta
<i>Trophy Award</i> —Mrs. J. R. S. Mays.....	Macon
<i>Special Committee</i>	
<i>Camellia Garden</i> —Mrs. R. W. Bradford.....	Milledgeville
<i>Civil Defense</i> —Mrs. Edgar Dunstan.....	Atlanta
<i>Members-at-Large</i> —Mrs. C. J. Roper.....	Jasper
<i>Revision of Awards</i> —	
Mrs. Ralph McCord.....	Rome
Mrs. Braswell Collins.....	Waycross
<i>Nurse Recruitment</i> —Mrs. Eustace Allen.....	Atlanta
<i>Library Service</i> —Mrs. J. H. Dew.....	Atlanta
<i>Georgia Products Festival</i> —Mrs. C. C. Aven.....	Atlanta

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<i>Second District</i> —Mrs. W. P. Rhyne.....	Albany
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<i>Fourth District</i> —Mrs. Virgil Williams.....	Griffin
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<i>Tenth District</i> —Mrs. Ralph Chaney.....	Augusta

Presidents of County Auxiliaries

<i>Baldwin</i> —Mrs. E. Y. Walker.....	Milledgeville
<i>Bibb</i> —Mrs. Max Mass.....	Macon
<i>Bulloch-Candler-Evans</i> —Mrs. W. E. Floyd.....	Statesboro
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<i>Coffee</i> —Mrs. Roy Johnson.....	Douglas
<i>Crisp</i> —Mrs. O. T. Gower.....	Cordele
<i>DeKalb</i> —Mrs. H. B. Lee.....	Decatur
<i>Dougherty</i> —Mrs. E. S. Armstrong.....	Albany
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<i>Glynn</i> —Mrs. Haywood Moore.....	Brunswick
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<i>Gwinnett</i> —Mrs. W. W. Puett.....	Norcross
<i>Habersham</i> —Mrs. Charles M. Henry.....	Clarksville
<i>Hall</i> —Mrs. E. L. Ward.....	Gainesville
<i>Jackson-Barrow</i> —Mrs. E. H. Etheridge.....	Winder
<i>Muscookee</i> —Mrs. Dave Berman.....	Columbus
<i>Randolph-Terrell</i> —Mrs. J. C. Patterson.....	Cuthbert
<i>Richmond</i> —Mrs. W. S. Boyd.....	Augusta
<i>South Georgia</i> —Mrs. J. G. Smith.....	Valdosta
<i>Stephens</i> —Mrs. H. H. McNeely.....	Toccoa
<i>Sumter-Schley-Macon</i> —Mrs. A. C. Primrose.....	Americus
<i>Tift</i> —Mrs. C. A. Fleming.....	Tifton
<i>Troup</i> —Mrs. Willis M. Hendricks.....	LaGrange
<i>Upson</i> —Mrs. James Woodall.....	Thomaston
<i>Ware</i> —Mrs. H. A. Seaman.....	Waycross
<i>Washington</i> —Mrs. Joseph E. Lever.....	Sandersville
<i>Whitfield</i> —Mrs. D. Lloyd Wood.....	Dalton
<i>Worth</i> —Mrs. Gordon Sumner.....	Sylvester

Woman's Auxiliary
to the
Georgia Medical Society
(Chatham County)

Convention Committees

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Mrs. George Straight, Co-Chairman

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Mrs. E. N. Gleaton Mrs. W. W. Osborne
Mrs. L. K. Powers Mrs. Vincent J. Cirincione
Mrs. J. Reid Broderick

THE PROGRAM

Headquarters, S.S.S.S. Club, 346 Bull Street
(One block South of Hotel DeSoto)

Registration

SUNDAY, MAY 11

11:00 A. M. to 9:00 P. M.—Lobby, Hotel DeSoto

MONDAY, MAY 12

9:00 A. M. to 12:30 P. M.—S. S. S. S. Club

3:00 P. M. to 5:00 P. M.—S. S. S. S. Club

TUESDAY, MAY 12

9:00 A. M. to 10:30 A. M.—S. S. S. S. Club

Program and Entertainment

SUNDAY, MAY 10

2:30 P.M. PRE-CONVENTION MEETING OF THE
EXECUTIVE BOARD
(All members invited)
Habersham Room, Hotel DeSoto.

3:45 P.M. JOINT MEMORIAL SERVICE.
Grand Ballroom, Hotel DeSoto
Presiding: C. F. Holton, President,
Savannah.

Invocation: The Rev. Ernest Risley,
Minister, St. John's Episcopal
Church, Savannah.

In Memoriam.

Benediction.

4:30 P.M. OPEN PUBLIC MEETING
(MAG Auxiliary sponsorship)
Grand Ballroom, Hotel DeSoto.

Presiding: Mrs. Ralph W. Fowler,
Auxiliary President, Marietta.

"Are We Educating or Indoctrinating

Our Children?", Mr. Arthur L. Con-
rad, President, The Heritage Foun-
dation, Inc., Chicago.

6:00-9:00 P.M. SOCIAL HOUR AND SMORGASBORD FOR
MEMBERS AND WIVES
(Ticket Required).

*General Oglethorpe Hotel, Wilming-
ton Island, Savannah.*

(Special bus service from the Hotel
DeSoto to be furnished).

MONDAY, MAY 11

10:00 A.M. GENERAL MEETING
S. S. S. S. Club.

1:00 P.M. LUNCHEON AT WILD HERON PLANTA-
TION—The historic home on this
plantation is recorded as the oldest
residence standing in Georgia and
is the home of Colonel and Mrs.
Shelby Myrick.

10:00 P.M. "ALL MY BABIES" (A film, restricted
for showing to physicians and wives,
sponsored by the Woman's Aux-
iliary).
Gold Room, Hotel DeSoto.

TUESDAY, MAY 12

10:00 A.M. GENERAL MEETING
S. S. S. S. Club.

3:00-5:00 P.M. TEA AT ST. JAMES PARISH IN HONOR
OF AUXILIARY STATE OFFICERS.
All members of the Woman's Auxil-
iary to the Medical Association of
Georgia invited.

- 5:30 P.M. RECEPTION FOR MAG MEMBERS AND WIVES Host, Central of Georgia Railroad.
Gold Room, Hotel DeSoto.
- 7:00 P.M. MAG PRESIDENT'S DINNER (All MAG members and wives invited)
Grand Ballroom, Hotel DeSoto.

GENERAL MEETING
S.S.S.S. Club, 346 Bull Street

MONDAY, MAY 11, 1953, 10:00 A. M.

CALL TO ORDER BY THE PRESIDENT—Mrs. Ralph W. Fowler, Marietta.

INVOCATION—The Rev. Jack Anderson, Pastor, Wesley Monumental Methodist Church, Savannah.

ADDRESS OF WELCOME—Mrs. Loyd Osteen, Savannah, President of the Woman's Auxiliary to the Georgia Medical Society (Chatham County).

RESPONSE TO ADDRESS OF WELCOME—Mrs. W. P. Rhyne, Albany.

INTRODUCTION OF HONOR GUESTS AND PRESIDENTS—Mrs. J. R. S. Mays, immediate Past President of the Woman's Auxiliary to the Medical Association of Georgia.

PANEL DISCUSSION:

Things We Need

I. MEMBERSHIP—Mrs. Leo Smith, Waycross, *Moderator.*

1. Membership Interest—How to Encourage, Mrs. A. C. Primrose, Americus (Sumter-Schley-Macon Counties).
2. Breaking Down Medical Society Resistance—Mrs. H. H. McNeely, Toccoa (Stephens County).
3. Friendliness and Unity—Mrs. John T. McCall, Rome (Floyd County).
4. Starting a New Auxiliary—Mrs. Roy L. Johnson, Douglas (Coffee County).
5. The Importance of the Member-at-Large—Mrs. C. J. Roper, Jasper (Cherokee-Pickens County).

II. BETTER PROGRAMS—BETTER MEMBERS—Mrs. Murdock Euen, Atlanta, *Moderator.*

1. Resources
 - a. Publications
 1. AMA Journal, Medical Economics, MAG Journal, Magazine, Auxiliary News—Mrs. Leon E. Brawner, Brunswick (Glynn County).
 2. Bulletin—Mrs. D. Hubert King, Dalton (Whitfield County).
 3. Today's Health—Mrs. Carlton A. Fleming, Tifton (Tift County).
 4. Handbook—Mrs. Grady Coker, Canton (Cherokee-Pickens County).
 - b. Use of Available Community Material—

Mrs. J. Gregg Smith, Valdosta (South Georgia).

c. Library Service—Mrs. W. E. Floyd, Statesboro (Bulloch-Candler-Evans Counties).

2. Suggested Programs

a. Small Auxiliary—Mrs. J. C. Patterson, Cuthbert (Randolph County).

b. Larger Auxiliary—Mrs. E. S. Armstrong, Albany (Dougherty County).

III. CURRENT TRENDS IN MEDICAL LEGISLATION—Mrs. Evert A. Bancker, Atlanta, *Moderator.*

1. Legislative Bills, Both State and National—Mrs. James A. Woodall, Thomaston (Upson County).
2. What We Can Do—Mrs. James H. Litton, Tucker (DeKalb County).

IV. AUXILIARY TO A. M. A.—Mrs. Leo Smith, Waycross, *Moderator.*

1. The Value of AMA Membership—Mrs. W. U. Hyden, Trion (Chatooga County).
2. AMA Services—Mrs. Joseph E. Lever, Sandersville (Washington County).

GENERAL MEETING

S.S.S.S. Club, 346 Bull Street

TUESDAY, MAY 12, 1953, 10:00 A. M.

CALL TO ORDER BY THE PRESIDENT—Mrs. Ralph W. Fowler, Marietta.

INVOCATION—Rev. Roseph L. Griffin, Savannah, Pastor, St. Paul's Lutheran Church.

PLEDGE OF LOYALTY—Mrs. George Hutto, Columbus.

INTRODUCTION OF PAGES—Mrs. Ralston Lattimore, Savannah.

ADDRESS—Dr. C. F. Holton, Savannah, President of the Medical Association of Georgia.

PANEL DISCUSSION:

What We Do

I. AIDS TO MEDICAL EDUCATION—Mrs. Shelly Davis, Atlanta, *Moderator.*

1. Student Loan Fund—Mrs. E. Y. Walker, Milledgeville (Baldwin County).
2. Nurse Recruitment—Mrs. Dave Berman, Columbus (Muscogee County).
 - a. Nurses Scholarship—Mrs. W. W. Puett, Norcross (Gwinnett County).
 - b. Special Courtesies to Nurses—Mrs. William Boyd, Augusta (Richmond County).
3. A. M. Education Fund—Mrs. Gordon S. Sumner, Sylvester (Worth County).

II. PUBLIC RELATIONS—Mrs. Walker L. Curtis, College Park, *Moderator.*

1. Planning for the Open Health Meeting for

Lay Groups—Mrs. Max Mass, Macon (Bibb County).

2. Newspaper, T. V., and Radio Publicity—Mrs. Edgar M. Dunstan, Atlanta (Fulton County).
3. Leadership in Community Service—Mrs. W. A. Risteen, Augusta (Richmond County).
4. Health Booth at the County Fair—Mrs. H. A. Seaman, Waycross (Ware County).
5. April Open House for Health Services—Mrs. Charles Henry, Clarkesville (Habersham County).
6. Essay Contest—Mrs. W. M. Hendricks, La-Grange (Troup County).

III. PROJECTS—Mrs. Ralph Chaney, Augusta, *Moderator*.

1. Crippled Children's Clinic—Mrs. O. T. Gower, Cordele (Crisp County).
2. Hospital Gift Shop—Mrs. Ed Marks, Marietta (Cobb County).
3. Clinic at County Children's Home—Mrs. W. L. Osteen (Chatham County).
4. Research in Romance of Medicine—Mrs. W. S. Worthy, Carrollton (Carroll-Douglas-Har-ralson County).
5. Doctor's Day—Mrs. A. B. Russell, Winder (Jackson-Barrow County).
6. Special Project—Mrs. E. L. Ward, Gainesville (Hall County).

ADDRESS—Dr. William P. Harbin, Jr., Rome, President-Elect of the Medical Association of Georgia.

REPORT OF AUDITING COMMITTEE.

REPORT OF RESOLUTIONS COMMITTEE.

REPORT OF REGISTRATION COMMITTEE—Mrs. Oscar Lott, Savannah.

REPORT OF AWARDS COMMITTEE:

Achievement—Mrs. Ralph Chaney, Augusta.

Scrapbook—Mrs. W. P. Stoner, Sylvester.

Brawner Cup for Excellence—Mrs. J. R. S. Mays, Macon.

REPORT OF COURTESY COMMITTEE.

BUSINESS.

REPORT OF NOMINATING COMMITTEE.

ELECTION OF OFFICERS.

PRESENTATION OF PRESIDENT'S PIN TO RETIRING PRESIDENT—Mrs. Joseph Yampolsky, Atlanta.

ANNOUNCEMENTS BY THE PRESIDENT—Mrs. Leo Smith, Waycross.

ADJOURNMENT.

Post-Convention Board Breakfast

WEDNESDAY, MAY 13, 9:30 A. M.

Mrs. Leo Smith, Waycross, President
Chatham Room, Hotel DeSoto.

Rules to Govern the Convention

1. To gain recognition, a delegates is requested to rise, address the chair, give her name and the name of her auxiliary.

2. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.

3. Reports shall not be read from Auxiliaries which are not represented by delegates but shall be filed with the secretary.

4. All original motions on resolutions shall be made by submitting two copies; one to the Resolutions Committee, and one to the Recording Secretary.

5. Reports of delegates and district managers are limited to two monutes.

6. No one is entitled to vote before she is registered.

7. All persons appearing on the program must be seated near the platform when the session opens.

8. Badges must be worn by members of the voting body during all general sessions of the convention.

9. Delegates' privileges are not transferable.

Whispering conversations greatly retard the business of the meeting; order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced. Reports must conform to the time allotted.

Pledge

"I pledge my loyalty and devotion to the "WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA." I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with fault-finding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And may we strive to teach and to know the great, common Woman's heart of us all, and O, Lord God, let us not forget to be kind."

Asynchronous Bilateral Benign

PAPILLOMA *of the* URETER

with Subsequent CANCER *of the*

URETERAL STUMP,

BLADDER *and* VAGINA

In the past decade reports of papillary tumors of the renal pelvis and ureter which were diagnosed early have appeared frequently in the literature. Better diagnostic methods and the urologist's awareness of the occurrence of these tumors are undoubtedly responsible for the early diagnosis. Champion, Fowler, Coleman and Florence¹ reported 6 cases at a meeting of the Medical Association of Georgia in 1949. On studying the literature, one cannot escape the impression that there is a difference of opinion among authors concerning the pathology and treatment of the tumors. It is the purpose of this paper to report the experience gained by observation of a case of multiple papillary tumors over a period of more than 10 years and to utilize the experience as a contribution to the clarification of the subject.

REPORT OF CASE

In 1941, I reported a case of benign papilloma of the left ureter in a 58-year-old woman.² The papilloma was located in the middle third of the left ureter. Following ureteronephrectomy, the patient felt well for eight years, but failed to have periodic checkups as advised and was seldom seen by me during that period.

In 1949, she admitted reluctantly that she had noticed blood in the urine. A papilloma in the middle third of the right ureter was diagnosed. Since she had only a solitary kidney, excision of the papilloma with fulguration of its base in the ureter was performed. The papilloma from the right ureter and the one from the left looked precisely alike; both were the size and form of a strawberry and were attached by a short pedicle to the mucosa of the ureter. The ureteral

¹Read before the Section on Urology at the One Hundred Second Annual Session of the Medical Association of Georgia, May 12, 1952.

ERNEST FELBER, M.D., Atlanta

wall appeared normal except for dilatation. The excision of the papilloma from the right ureter was accomplished by ureterotomy. The ureter was incised longitudinally corresponding to the palpable tumor. The papilloma was easily delivered, and the base of the short, tiny pedicle was fulgurated. Preoperatively, a ureteral catheter was introduced into the ureter up to the tumor. Following removal of the papilloma, a rubber catheter size 12 French was attached to the catheter introduced preoperatively, and with it as a guide the rubber catheter was brought out through the urethra and left inlying for 10 days. The incision in the ureter was closed with chromic catgut size 00. Convalescence was uneventful.

Urologic examination before excision of the papilloma of the right ureter revealed a normal left ureteral stump remaining from the operation in 1941.

Following this successful operation, the patient made a fateful decision. She became a Christian Scientist and refused medical advice. Consequently, she did not return for a checkup.

In 1951, when she was seen again after an interval of two years, she complained of severe pain in the left inguinal region and constipation. Furthermore, she admitted having blood in the urine and frequency for some time. She was admitted to St. Joseph's Infirmary.

On cystoscopic examination, a tumor was seen protruding slightly from the left ureteral ostium, and on vaginal examination, a tumor the size of a goose egg was felt involving the vaginal wall and vesical wall in the region of the left ureteral ostium. Diagnosis of carcinoma of the left ureteral stump, the vagina and the bladder was made. The right kidney and ureter were normal.

The patient consented to an operation for the removal of the tumor most reluctantly and only because the pain was unbearable. A Gibson incision was made, and a tumor was exposed which involved the left ureteral stump, the left wall

of the bladder and the vagina. It was removed mostly by sharp dissection. The left vesical wall was incised along a radius of 4 cm. around the ureteral orifice, and a margin of at least 1 cm. of normal-appearing vesical wall was left attached to the tumor. Then the tumor with the involved portion of the vaginal wall was excised. No signs of glandular invasion were present. The defect in the bladder and vagina was closed by two rows of catgut sutures. A retention catheter was left inlying in the bladder. Convalescence was uneventful except for a short period of leakage of urine through the wound.

The pathologic diagnosis was carcinoma grade III, probably of transitional cell origin. This highly malignant tumor involved the vesical wall, the ureteral stump and the vaginal wall. Dr. Warren B. Matthews, the pathologist who made the diagnosis, was unable to determine the organ of origin of the tumor. He was kind enough to examine the papilloma removed in 1941 and confirmed the previous diagnosis of benign papilloma. He stated that it was altogether unlike the tumor removed in 1951. There was no indication that the malignant tumor was a metastatic lesion of the benign papilloma.

Discussion

In summary, the findings in this case during the 10 year period of observation were: Nephroureterectomy was performed in 1941 on a 58-year-old woman for benign papilloma of the left ureter. In 1949, a papilloma of the right ureter corresponding in size and situation to the papilloma removed in 1941 was removed by excision. Two years later, in 1951, a highly malignant carcinoma of the ureteral stump, the left lateral vesical wall and the vaginal wall was excised.

I should like to recommend a Gibson incision for removal of vesical tumors involving the ureteral ostium or in the proximity of it. If the Gibson incision is carried almost to the symphysis pubis, a good exposure of the lateral and posterolateral walls of the bladder is possible, and excision of the tumor including the ureter is easily accomplished. The ureter might be reimplanted into the bladder or taken care of in any way required in the particular case. This exposure has the advantage of facilitating the removal of tumors almost impossible to remove by suprapubic incision, and also of permitting the inspection and removal of retrovesical glands. Hess³ recommended a similar procedure at the last meeting of The Southeastern Branch of the American Urological Association.

There are several questions concerning papillary tumors in the urinary tract that urologists and pathologists cannot answer definitely. One question is, "How is the multiplicity of papillary tumors brought about?" Frequently, multiple tumors appear simultaneously, or there may be recurrence after removal of the first tumor. Four theories have been advanced to explain the multiplicity of papillary tumors in the urinary tract: (1) the theory of implantation, (2) the theory of multicentric origin, (3) the theory that tumors spread by direct extension along mucous membranes, and (4) the theory that tumors spread by metastasis by way of the lymph vessels.

Another question is, "Can a histologically benign papillary tumor change its histologic characteristics into those of a malignant epithelial tumor?" Both questions should be answered in my case. A benign papilloma recurred eight years after removal of the

Special Notice to Internists

The Georgia Chapter, American College of Physicians announces the calling of a special organizational meeting at a Luncheon, at 1:00 p.m., Wednesday, May 13. This meeting is called by Dr. Carter Smith, Governor.

Make reservation in advance to: Dr. Edgar Dunstan, Doctors Building, Atlanta.

first one; two years after removal of the second papilloma a malignant tumor was observed.

In 1951, Kaplan, McDonald and Thompson⁴ discussed the origin of papillary tumors of the urinary tract and came to the conclusion that the multiplicity of the tumors can best be explained on the basis of multicentric origin. In other words, the tumors originate from multiple independent foci. Ewing⁵ stated that multiplicity of papillary tumors is often the result of factors affecting the entire mucous membrane of the urinary tract. In my case a second papilloma developed in the opposite ureter seven or eight years later and cannot possibly be explained by implantation of neoplastic cells exfoliated from the primary tumor, carried in the urinary stream and deposited in the opposite ureter. Equally difficult or almost impossible to explain would be the spread by direct extension or by way of the lymph vessels. The development of the carcinoma 10 years following the removal of the first tumor, on the same side, speaks for an independent focus and the possibility that in the same person foci of benign and malignant tumors might be present.

Assuming that the theory of multicentric origin of papillary tumors is correct, what can one learn concerning the treatment? In 1945, Vest⁶ advocated conservative surgery in the treatment of certain benign tumors of the ureter with excision of the tumor only, a method which met with some opposition. I am inclined to agree with him if one is reasonably sure that he is dealing with a solitary benign tumor of the ureter, if it is a tumor of the ureter with benign clinical appearance not involving the ureteral wall, and if the pathologist confirms the diagnosis by rapid operating room biopsy.

In 1949, when the second papilloma developed in the right ureter in my case, I was forced to confine the operation to excision of the papilloma, and there was no recurrence in a period of over two years. It is of course true that the more epithelium of the urinary tract one removes, the less epithelium is left for recurrence of tumors. The entire ureter including a cuff of the bladder should be removed once ureteronephrectomy is decided upon regardless of whether it is performed for benign or malignant tumor, because the ureteral stump is useless and may become the site of a recurrent tumor. On the other hand, the possibility of tumors appearing not neces-

Note Your Specialty Society Luncheon and Attend

Specialty society luncheons are slated for the following times; see Bulletin Board for locations.

GEORGIA PEDIATRIC SOCIETY, 1:00 p.m., Monday, May 11.

GEORGIA RADIOLOGICAL SOCIETY, 1:00 p.m., Monday, May 11.

GEORGIA UROLOGICAL SOCIETY, 1:00 p.m., Monday, May 11.

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS, 1:00 p.m., Monday, May 11.

GEORGIA ACADEMY OF GENERAL PRACTICE, 1:00 p.m., Tuesday, May 12.

GEORGIA INDUSTRIAL SURGEONS ASSN., 1:00 p.m., Tuesday, May 12.

GEORGIA ASSOCIATION OF PATHOLOGISTS, 1:00 p.m., Tuesday, May 12.

GEORGIA STATE SOCIETY OF ANESTHESIOLOGISTS, 1:00 p.m., Tuesday, May 12.

GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY, 1:00 p.m., Tuesday, May 12.

GEORGIA ORTHOPEDIC SOCIETY, 1:00 p.m., Tuesday, May 12.

GEORGIA CHAPTER, AMERICAN MEDICAL WOMAN'S ASSN., 1:00 p.m., Tuesday, May 12.

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY, 1:00 p.m., Wednesday, May 13.

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS AND GEORGIA TRUDEAU SOCIETY (Combined Luncheon), 1:00 p.m., Wednesday, May 13.

sarily simultaneously in both renal pelves or ureters should make one think.

O'Connor⁷ advocated total nephroureterectomy in every case of papillary tumor of the ureter and did not like the distinction between malignant and benign papillary tumors of the ureter in view of the fact that every papillary tumor of the ureter is potentially malignant, an assumption not agreed upon by many urologists and pathologists. Papillary epitheliomas which give no evidence of infiltration of the subjacent wall, do not metastasize, and are lacking in histologically atypical mitoses and cell arrangements are considered benign tumors by many pathologists. The tumors are included in grade I in Broders' classification. Referring to the tumors as grade I cancer does not mean they are malignant or have all the characteristics of a malignant tumor. Ewing⁵ stated that benign papillomas are known to have existed for six, 12 and 27 years. Vest⁶ could not find in the literature a definite proof that a benign papillary tumor recurred and changed its characteristics into a malignant epithelial tumor. One of course does not know how long a papilloma has existed prior to diagnosis.

In my case, symptoms were present for at least a year before the patient came under my care.

If the theory of multicentric origin of papillary tumors is correct, and if in the same person foci of benign and malignant tumors are present, one might be in a predicament if he removes kidney and ureter for a benign papillary tumor of one ureter and there should develop a malignant tumor in the other ureter where nothing short of a radical procedure could be considered. If in the case presented the second papilloma occurring in the remaining ureter had been malignant, the excision would have been insufficient, and the patient could not have lived more than a few months. This is one reason why I think one should consider most carefully the choice of the operative procedure in cases of solitary benign papilloma of the ureter.⁶

Summary

The case presented seems to support the theory of multicentric origin of papillary tumors in the urinary tract and seems to show that in the same person foci of benign and malignant tumors might be present in the urothelium.

Consequently, the treatment should be as follows:

In malignant papillary tumors of the ureter complete nephroureterectomy including a cuff of the bladder is imperative.

If nephroureterectomy is performed for benign papillary tumors of the ureter, total nephroureterectomy including a cuff of the bladder should always be carried out.

Certain benign single papillary tumors of the ureter can be treated conservatively if it is worth while to preserve the kidney of the involved side and the tumor is proved clinically and pathologically to be benign. Rapid operating room biopsy is imperative.

Once a papillary tumor in the urinary tract has been found, regardless of the chosen treatment, periodic checkups at intervals not exceeding three to six months, including complete urologic study, are essential for the rest of the life of the patient.

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A short time after this paper was read, there appeared in the *Southern Medical Journal*, issue of June 1952, an article entitled "Benign Tumors of the Ureter" by W. V. Pierce, M.D., and W. R. Miner, M.D., in which the authors came to a similar conclusion concerning the treatment of benign ureteral tumors.

Carcinoma of the colon responds most favorably when early and adequate treatment has been rendered. There are many factors which determines the prognosis and for that reason we are endeavoring to set forth those things influencing this disease. The prognosis must be considered from the standpoint of permanent cure and the correction of the existing symptoms.

It has been shown that in patients who have carcinoma of the colon, without extension beyond the primary site, and who withstand the operative removal, there is a 50 to 60 per cent five year survival. In the presence of lymph nodes there is 25 to 40 per cent, five year survival rate. Allen¹ has recently reported 44 per cent living at the end of five years

Factors Influencing the

PROGNOSIS *of*

CARCINOMA *of the* COLON

when a resection was done. The ability to make life more tolerable and to appreciably prolong life, is desired even in the presence of advanced disease. If there is an associated obstruction, the patients can be made more comfortable provided the tumor is resected. Every effort, however, should be made to restore the continuity of the bowel when a compromise palliative procedure is done. Although the basic principles of surgical therapy have been known for many years, it has been only within the past decade that with new methods and procedures has statistical improvement been noteworthy. This gratifying result has been made by early diagnosis through awareness by the patient and the physician. Great credit must be given to the usage and understanding of the methods of control of the intestinal infection, to adequate use of blood, electrolytes and nutritional requirements. Anesthesia has been made more safe and permits a more definitive treatment even when the optimum time may appear to be exceeded. More recently attempts are being made to remove advanced disease after it has extended beyond its primary site.

A majority of the patients when seen by the surgeon are now operable whereas a few years ago they were inoperable. If the process can be resected, it should be done in all instances even in the presence of obvious metastasis. This will obviate secondary infections, avoid obstruction and prevent bleeding during the terminal phases of the disease. Resectability can be judged by the ability to mobilize the lesion without disturbance of the function of vital organs. Resection of other involved structures may be indicated to remove all disease.

The mortality from such a procedure where the colon alone is involved, may be less than five per cent. In the presence of advanced disease, extensive

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resection may carry 30 per cent operative risk. Even so, the ability to salvage the occasional patient is worthwhile since it is certain that the mortality without treatment is 100 per cent. The curability depends on early recognition or more important, an adequate removal of the lesion.

The approach, therefore, must be a positive one in which all calculated risks are made and in each instance something definite should be offered. Palliation is recommended for the relief of pain, prevention of obstruction and the overall improvement of the patient's comfort.

The factors concerned in all carcinoma of the colon are three in number. Namely, that the process is of course a malignant one of a variable degree, manifesting either a slow or rapid growth. The second factor is infection within the intestinal tract and subsequently an involvement of the wall of the bowel and the surrounding tissue. The third factor is the presence or absence of obstruction.

The problem of nutrition and restoration of the blood for the anemia, which is seen often even with the early lesion, is paramount. Lesions of caecum and ascending colon are seldom obstructed and necessitate a preliminary decompression or intestinal intubation. Transverse and descending colon, however, may have associated infection and or obstruction depending on the stage of the disease. The use of intestinal intubation in the presence of an obvious obstruction is only valuable if an incompetent ileocecal valve exists. This is unusual and can never be relied upon when complete obstruction exists. Preliminary decompressions are then essential for safe removal of the tumor. A cecostomy

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Read before the Section on Surgery at the One Hundred Second Annual Session of the Medical Association of Georgia, May 13, 1952.

General Surgeons—Excise This!

Highlighting the Annual Session program are some "musts" on the General Surgeon's meeting list. Especially of interest are the following presentations. At 10:00 a.m. Tuesday: Symposium—"Vascular Surgery"; at 9:00 a.m. Tuesday: Symposium—"Orthopedics and Trauma"; at 2:00 p.m. Tuesday: Symposium—"Burns"; and the Section on General Surgery at 2:00 p.m. on Monday afternoon.

for decompression in most instances is inadequate since it does not function satisfactorily except in an occasional case where obstruction is near the hepatic flexure or ascending colon. The desirable procedure, in a non-obstructed lesion, is the immediate removal of the tumor and sufficient portion of the uninvolved bowel with an adequate amount of the adjacent mesentery, and with an immediate anastomosis.

Obstructive lesions on the left side of the colon can best be decompressed by a preliminary transverse colostomy. However, if obstructive resections are desired, a Mickulicz procedure may be accomplished. If there is any question, a preliminary decompression should always be performed for the relief of the obstruction and secondly to allow resolution of the associated infection. As has been stated, a primary resection and immediate anastomosis should be undertaken only when no obstruction exists and where preliminary chemotherapy or antibiotics have been administered.

Since Miles first in 1908² proposed the performance of an abdominoperineal resection for carcinoma of the rectum in one stage, many modifications of this procedure have been made. However, essentially the aim has been the total removal of the primary rectal growth, and an adequate amount of the adjacent tissue. Anything other than wide removal is a compromise, and must be considered as such with the present concept of therapy in this disease. Modifications in treatment have been directed towards making the procedures more safe. Two outstanding examples of such improvements have been contributed by Lahey³ and Rankin.^{1 4} Both recommend that the abdominoperineal resection be done, in stages with the performance of a preliminary colostomy later followed by resection of the lower segment in the same manner as was initially advocated by Miles. These procedures require additional opening of the abdomen and are met with the added risk in an additional operation. The present use of the antibiotics lessens the need for such a routine except in the occasional debilitated patient with a high lesion with considerable fixation and associated infection.

Dixon⁵ advocates an anterior resection of the lower recto-sigmoid lesions. Many criticisms of this procedure are based on the fact

that inadequate resections are performed and insufficient surrounding tissue is removed. Among other reasons the compromise is made to avoid a colostomy. Most patients when properly educated can become adjusted to the inconveniences of a properly functioning colostomy. Many difficulties may be encountered in performing anterior resections: (1) the lesion may be adherent, (2) there may be direct extension in either direction, (3) an associated infection may involve the wall and adjacent tissues which interferes with the viability of the remaining segment of the bowel and lastly, the lesion may be so low within the recto-sigmoid that a safe technical restoration of the bowel cannot be accomplished. It has been recommended that no attempts should be made to reestablish the continuity of the bowel less than 10 centimeters from the anus.

Babcock⁶ has attempted to preserve the function of the sphincter and avoid a colostomy by the performance of the so-called "pull through" procedure. This essentially is the resection of the involved bowel with preservation of the sphincter and bringing the proximal segment through the sphincter to the outside. This also is a compromise and may be inadequate to cure the disease. If viability of the intestine is to be maintained, an adequate amount of involved tissue cannot be removed. It has been shown by Gilchrist and David⁷, that the extension of the disease in the lower segment occurs more readily at the level of the levator ani muscle. Extension is less marked above and below this site.

It has been proposed by Clark⁸ that the combination of the anterior posterior resection in stages may safely accomplish what is desired. The preliminary procedure is the same as has been advocated by Lahey and a permanent colostomy be performed in usual manner. The distal segment is mobilized approximately half way to the outside. Between stages, the inflammatory disease subsides which allows a much easier complete removal. Another advantage of this procedure is that it does not require the second opening of the abdomen and each operative procedure is shortened by approximately 50 per cent. This is particularly advantageous in the more debilitated older patients with advanced disease.

Brunschwig⁹ and Sugarbaker¹⁰ have reported worthwhile results in treating late disease in which there is an involvement of the adjacent organs. It has been shown that the lymphatics frequently become blocked by disease and there is an absence of spread beyond the pelvic organs. The prostate, bladder, seminal vesicles in the male and the bladder, the uterus, the vagina, the rectum and all the surrounding tissue in the female are removed. This procedure, which appears radical, may be indicated in some instances since they are hopeless otherwise. The disability and inconvenience of a wet colostomy may be annoying when the ureters are implanted into the colon.

State¹¹ advocates extending the upward dissection in the Miles procedure to purposely include the inferior mesenteric, left colic arteries and all the nodes in this area. A bloc resection is made in the posterior peritoneum along the aorta, thereby removing the

sigmoid, entire left colon and half of the transverse colon, leaving a transverse colostomy. Such a resection removes the route of spread of disease and should increase the five year cures.

Multiple lesions occur in a small percentage of instances, either as concomitant separate lesions or a subsequent new primary carcinoma. This should be remembered in the initial examination and in the follow-up.

It is recognized that most polyps, if untreated, will become malignant and should be removed before malignancy develops. When a malignant polyp is demonstrated, the mode of treatment may vary. If a single polyp shows malignant characteristics, it may be sufficient to excise an adequate amount of the intestine without the performance of a wide resection. When multiple polyps exist, complete resection of the colon or segments of the colon is in order. The performance of this procedure in single or multiple stages has been the question of much debate and the opinion is that multiple resections may be more safely accomplished but occasionally a single stage procedure may be carried out.

In summary, it might be stated that carcinoma of the colon, when properly treated, is one of the most favorable of all neoplastic lesions. The presence or absence of associated disease, the age of the patient and the general state of nutrition, are initial factors influencing the disease. The characteristics of the lesions are important, not only from the standpoint of treatment but also the prognosis. It is believed that carcinoma involving the left side of the colon usually manifest early symptoms and are treated before the tumors on the right side. The duration of the symptoms usually indicate the stage of the disease which would influence the course. The presence of infection or obstruction is significant in early treatment and prognosis.

There is a wide variation of the behavior pattern of carcinoma in any site and those of the colon are no exception. It has been shown repeatedly that the patient with a so-called favorable lesion may succumb to the disease early and the opposite has been experienced. There must be unknown biologic factors which determines the course.

The presence of metastases is important in the prognosis, but the presence of such does not forbid operative removal even for palliation. Multiple lesions, appearing concomitantly or subsequently, influence the course. The preparation of the patient, the anesthesia, and the performance of surgery in single or multiple stages are significant in determining the outcome.

These factors which have been enumerated influence to a great extent the complications which develop subsequent to the surgery and are directly responsible for the results anticipated in patients with carcinoma of the colon.

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General Practitioners—Read This!

A special series of papers and discussion has been scheduled for the General Practitioner. The following list can serve as a G.P. guide to the Annual Session program. At 9:00 a. m., Monday: Symposium—"Neuropsychiatry in General Practice"; at 3:30 p.m., Monday afternoon: Symposium—"Radiological Procedures in General Practice"; at 9:00 a.m. Tuesday: Symposium—"Gastroenterology"; and at 9:00 a.m. Wednesday: Symposium—"Urology in General Practice."

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DISCUSSION

DR. JULIAN K. QUATTLEBAUM (Savannah): The remarks of the authors are sound, concise, accurate, right up to date, and yet, nothing has been left out.

We know that carcinoma of the colon, by and large, is a comparatively favorable site for cancer therapy. Any part or all of the large bowel can be removed, and if a permanent colostomy must be accepted, it is certainly not an unendurable condition. One usually quickly adjusts to this abnormality and is able to live a very normal existence with it. I expect all of us have seen patients with a temporary colostomy who preferred to keep it rather than submit to another operation for its closure. I have several such in mind. The fear of a permanent colostomy should not lead us to compromise with sound surgical principles in borderline cases.

There is no other field of surgery in which careful and adequate preoperative preparation is more essential to success, than surgery of the colon. Fortunately, we now have adequate means of overcoming infection, correcting anemia, relieving obstruction, improving associated pathological conditions that were undreamed of in the memory of many of us here today. We have seen the wonderful improvement resulting from them, but we also remember that before these wonderful aids were available, this dangerous field could be successfully invaded by adhering carefully to all the well established principles of surgery, and these modern miracu-

Industrial Surgeons Assn.

A special feature on the program is the Symposium on Burns, at 2:00 p.m., Tuesday, May 11. Col. Joseph R. Shaeffer, MC, USA, Chief of the Surgical Consultants Division, Surgeon General's Office, Washington, D. C., will discuss "The Mass Treatment of Burns in Atomic Warfare." George S. Tootle, Atlanta, will present "The Early Treatment of Burns" and S. A. Roddenberry, Columbus, will speak on "The Late Treatment of the Severely Burned Patient." Discussors include Milford B. Hatcher, Macon; Kirk Shepard, Thomasville; Edward S. Marks, Marietta; and John R. Lewis, Atlanta.

lous adjuncts should in no way encourage us to take anything for granted or to tolerate carelessness or indifference in the handling of a case of carcinoma of the colon.

One must agree with Dr. Martin that the primary growth should always be removed if possible, even should known metastases be present which make cure impossible. The patient is better off than with a palliative procedure which does not include removal of the original site of the tumor.

It is a surgical axiom that the obstructed bowel not be divided, and one should never attempt to remove the growth in the presence of obstruction. In decompressing the obstructed large bowel, a transverse colostomy has many advantages over lesser procedures.

The availability of antibiotics and chemotherapy, unlimited quantities of blood, better anesthesia and most important, better anesthetists, has greatly extended the range of all

surgery and has brought the benefits of radical procedures to even the very aged. However, many surgeons question the wisdom of the tremendous surgical adventures that are now being done in some centers. Such operations as the removal of all the pelvic organs, leaving the patient with a wet colostomy and other miserable complications, should not be lightly undertaken. However, the removal of solitary metastases in the liver or lung may at times, be clearly indicated. The removal of the entire left colon in operations for carcinoma of the rectum, leaving the patient with a transverse colostomy, also demands thoughtful application. Certainly an adequate cancer operation requires the removal of the main vessel with its accompanying glands and lymphatics by a single block dissection, with ligation at as high a level as possible. The inferior mesenteric artery should be ligated at the aorta, and even the left colic should be included in the dissection at times. Simple routine wedge resection for carcinoma of the sigmoid is definitely an inadequate procedure and should be discontinued except for the very poor risk patients. In treatment of carcinoma of the colon, the possibility of multiple lesions should always be borne in mind and a careful examination of the entire bowel carried out in each exploration.

The application of operative procedures for colon lesions requires sound surgical judgment. Zeal should not outrun discretion. The attempt to do an anterior resection of the rectum in a fat patient with a small pelvis can lead only to disaster, while the old style loop colostomy followed by a posterior resection can give many years of cure and comfort to the elderly individual. One should do what he feels he can do best under the conditions and circumstances of his own surroundings, rather than be swayed into attempting some complicated surgical maneuver, using some fancy gadget which he may have read about in one of the current journals.

I can only congratulate Dr. McRae on his remarkable presentation, since I have never seen a case of familial polyposis, or if so, I failed to recognize it. I have never heard a more interesting paper. It certainly should make us more alert to this possibility, and if a case is discovered, we should follow Dr. McRae in tracking down the symptomless relatives and giving them the opportunity of escaping certain malignancy by prompt colectomy.

Better Health Council

of Georgia

Dr. William Harbin, President-Elect, Medical Association of Georgia, greeted the Northwest Regional Health Conference, held in Lindale, Georgia, March 17. This conference was attended by over 275 community and professional people.

Following Dr. Harbin's talk on "The Progress of Health in the Northwest Region," Dr. Frank Vinson, Chairman, Committee on Rural Health, Medical Association of Georgia, spoke to the conference, emphasizing that the people in the community can secure the health services needed for themselves if they will work in a group towards a better health goal.

A round-table on "School Child Health" was well presented, with excellent individual participation from the audience.

In the afternoon, Dr. D. Loyd Wood, member of the Committee on Health Insurance, added to the urgency of the appeal for people to secure good health insurance.

Mr. Oscar Hilliard, President, Georgia Hospital Association, presented the subject from the view point of a hospital administrator.

Dr. S. C. Rutland presented "How to Secure Public Health Services" and Mr. L. C. Williams, rounded out the day's conference with a discussion on "Environmental Sanitation."

Representatives were present from every group in the communities and the 26 counties which make up this area.

TUMORS *of the* NECK

In the Robert Winship Memorial Clinic at Emory University Hospital, the problem of diagnosis and treatment of tumors of the neck has been a frequent and sometimes difficult one, and it is the purpose of this paper to present to you those aspects of the problem which seem to be of greatest importance.

The single fact of greatest significance is that a tumor situated anywhere in the neck except in the midline or in the thyroid area is more likely to be a manifestation of malignant neoplastic disease arising elsewhere than it is to represent a tumor primary in the neck. As a rule there is no pain and there are no symptoms except for the appearance of a firm, non-tender, gradually enlarging tumor. This may be and often is the first sign of carcinoma which has its origin elsewhere but which has not indicated its presence by symptoms related to the primary lesion. If there is invasion or displacement or surrounding structures, there may be difficulty in swallowing, difficulty in breathing, hoarseness, or pain. If the sympathetics are involved, a Horner's syndrome may be present on the involved side. As a rule, however, the tumor when first detected will be in an earlier stage and will give rise to few if any symptoms.

The history which the patient gives may be misleading. Just because the tumor has been present for 18 months, for example, without apparent change does not mean that it is benign. We have had a recent patient with carcinoma of the thyroid with cervical metastases in whom the metastatic node was apparently present for about a year and a half without causing any symptoms whatever. The age of the patient is of very little help. Tumors both benign and malignant can occur at any age. The characteristics of the tumor as determined by palpation are important. There is a distinction between enlargement of lymph nodes and palpability of lymph nodes. Many normal people have palpable lymph nodes of the neck. Asymmetry is clinically significant and induration of a node is also significant even though the node may not be large. Metastatic squamous cancer is usually quite hard. Metastatic thyroid carcinoma can be less indurated and may even have cystic areas associated with it. Metastatic adenocarcinoma is usually definitely firmer than a node enlarged because of acute or

chronic inflammation. The observation that "it feels like cancer" is often a valid one but of course must be verified by further study. The mobility of the mass is important not only as an aid to determining its probable etiology but also as an aid in determining operability because if the malignant growth has grown diffusely into the tissue of the neck, its complete removal may be difficult or impossible. Mobility is usually associated with an encapsulated tumor and is frequently impaired when the growth has broken through a restraining capsule. Sometimes a readily palpable hyoid bone or a cornu of the thyroid cartilage will simulate a metastatic lymph node and an enlarged and sclerotic carotid bulb can also be mistaken for metastatic lymph nodes at the carotid bifurcation. Definite pulsation is helpful in making the differentiation. Whether the mass is cystic or solid is important. If necessary, a small needle may be inserted into it under novacaine anesthesia to determine this point. When searching the oral cavity, nasopharynx, pharynx, and larynx for a primary carcinoma, a good light is essential as is facility in the use of laryngeal and nasopharyngeal mirrors.

The location of the tumor in the neck is a guide to the probable location of the primary neoplasm. Since most carcinomas of the head and neck metastasize by way of the lymphatics, a knowledge of the lymphatic pathways is very helpful not only in predicting where a metastasis is likely to appear but also in tracing back from a demonstrable metastasis

Vocational Rehabilitation

Do you know what the Vocational Rehabilitation Agency does in your state . . . and how they do it? Attend and learn at a special Panel Discussion, Monday morning at 9:00 a.m. Carl C. Aven, of Atlanta, will moderate with Mr. A. P. Jarrell, Assistant Director, Division of Vocational Rehabilitation, Atlanta; Thomas P. Goodwyn, Atlanta; Julian K. Quattlebaum, Savannah; Lester Harbin, Rome; Milford B. Hatcher, Macon; and Braswell E. Collins, Union Point, as Discussants on the subject "The Program of Vocational Rehabilitation in Georgia."

Read before the Section on Surgery at the One Hundred Second Annual Session of the Medical Association of Georgia, May 13, 1952.

From the Robert Winship Memorial Clinic, Department of Surgery, Emory University School of Medicine.

to the area in which one would expect to find a primary. If an indurated tumor develops in the submental area, one should look carefully in the lips and in the anterior floor of the mouth for a possible primary carcinoma. If the tumor is in the submaxillary region, the skin of the face, the lips, the floor of the mouth, the tongue, and the buccal mucosa are very likely sites (Fig. 1). If the tumor appears beneath the posterior belly of the digastric muscle or in the region of the bifurcation of the carotid artery, one should carefully examine the tongue, the tonsil, the pharynx, and the palate for evidence of a primary lesion (Figs. 2 and 3). If the tumor of the neck appears just beneath the upper third of the sternocleidomastoid muscle, sometimes extending just posterior to it, a primary tumor in the nasopharynx is a very good possibility (Fig. 4). Nasopharyngeal carcinomas can be difficult to find. Repeated examination may be needed to locate them. In the supraclavicular area enlarged nodes may well be secondary to carcinoma of the breast, stomach, esophagus, lung, uterus, or testis and more rarely to other primary sites (Fig. 5). Metastatic carcinoma from the thyroid may appear in the upper third of the neck at the posterior margin of the sternocleidomastoid muscle or in the region of the bifurcation of the carotid, or it may involve nodes in the lower portion of the neck adjacent to the thyroid first (Fig. 6). Conversely, carcinoma of the tongue may give its first

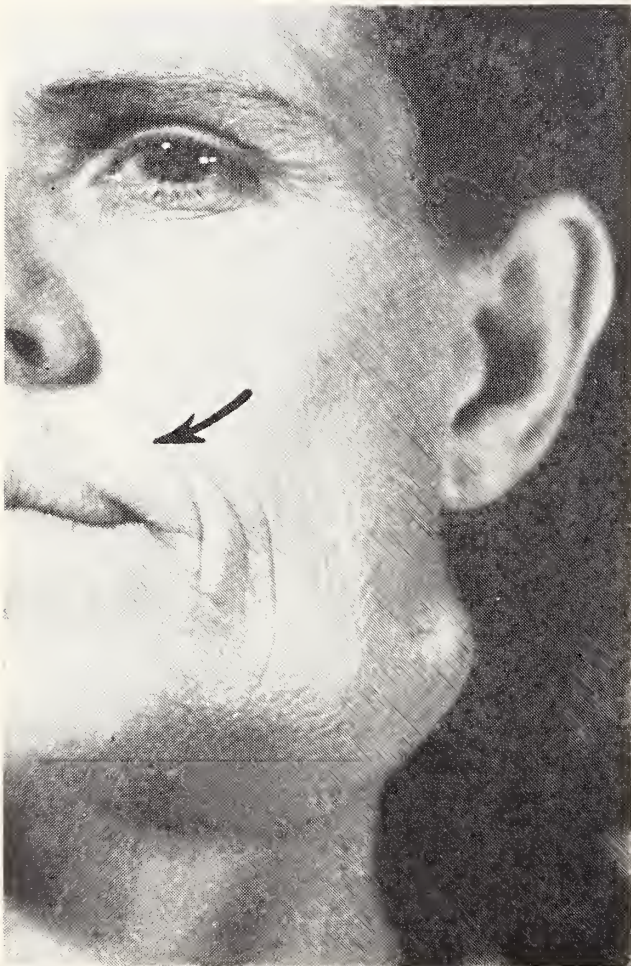


Figure 1. Squamous cell carcinoma involving left submaxillary lymph nodes. No recurrence at site of primary lesion in left upper lip.



Figure 2. Metastatic involvement of left cervical node from carcinoma of soft palate.



Figure 3. Squamous cell carcinoma of soft palate in same patient.



Figure 4. Cervical metastases from carcinoma of nasopharynx.

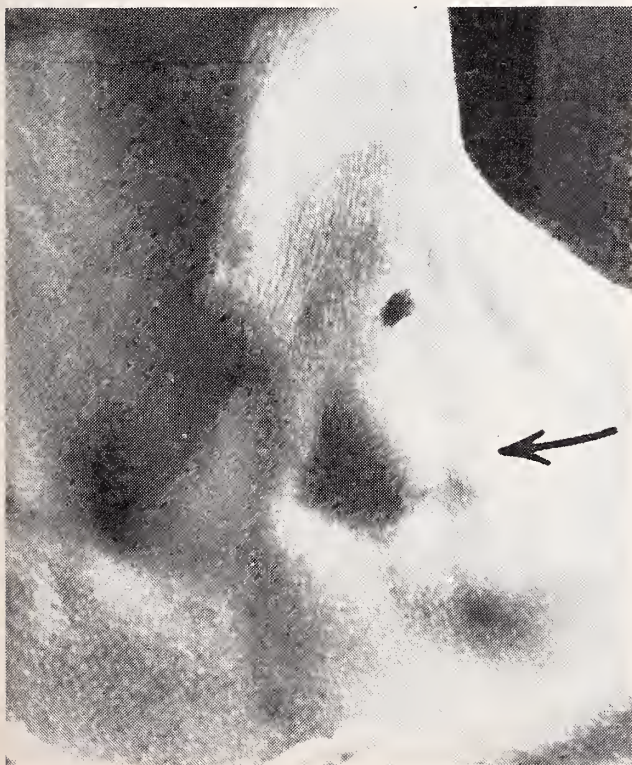


Figure 5. Metastatic squamous cell carcinoma in left supraclavicular node from carcinoma of cervix.

evidence of metastatic spread by an enlarged node in the lower third of the neck although as a rule it involves upper cervical nodes before extending lower in the neck. If the tumor of the neck is part of a generalized adenopathy, it may be due to one of the lymphomas or to leukemia. Enlargement of lymph nodes due to acute inflammatory changes are not frequently confused with those due to neoplastic origin since tenderness, fever, pain, and an obvious primary site of inflammation are usually readily apparent. Chronic inflammation associated particularly with tuberculosis or syphilis may present a diagnostic problem and microscopic study of the involved node may be necessary to settle the question.

When a tumor appears in the neck lateral to the midline, the first step is not to remove the tumor but to look for a possible primary carcinoma which may be associated with it. If this cannot be found aspiration biopsy is often helpful in establishing the diagnosis. A 20 cc. record syringe which has a metal piston and a 17 gauge needle should be used. Syringes which have a glass piston seldom develop enough suction and a needle smaller than 17 gauge seldom yields adequate tissue for microscopic examination although it can be helpful at times in distinguishing a cyst from a solid tumor. If the cells of the tumor are characteristic of squamous carcinoma, the primary lesion is probably located somewhere in the oral cavity and another search should be made. If



Figure 6. Cervical node metastases from carcinoma of thyroid.

no primary is found there, other sites for the development of squamous carcinoma such as lung and cervix should be checked. On the other hand, if the aspiration biopsy reveals a mucous secreting adenocarcinoma, a tumor of the gastro-intestinal tract is suspected. When the tissue is consistent with a teratoma, a malignant tumor of the testis is a likely primary. If thyroid tissue is found in a nodule situated laterally in the neck definitely separate from the thyroid gland, the presumptive diagnosis is carcinoma of the thyroid even though the aspirated tissue may be well differentiated and bear a close resemblance to normal thyroid.

If aspiration biopsy is inconclusive and if no primary carcinoma can be found, excision of the tumor should be done. However, if there is evidence that the tumor in the neck is metastatic carcinoma, the prognosis for the patient is better if the lymph nodes in the neck are removed en bloc after control of the primary lesion, than it is if a single node is excised first thus disturbing lymphatic pathways and opening the way for dissemination of carcinoma in the soft tissues of the neck.

Even though the greatest importance of a tumor in the neck is the possible relationship to carcinoma, it is true that a number of tumors are actually primary in the neck. If the tumor arises in the midline

between the thyroid cartilage and the hyoid bone, it may well be a thyroglossal duct cyst (Fig. 7). It is due to failure of the thyroglossal tract to close. Thyroglossal cysts are apt to recur unless completely removed and it is necessary to divide the hyoid bone and pursue the thyroglossal duct beneath the hyoid until it is completely excised. Lingual thyroid is the rarest of the midline tumors. It is due to failure of the thyroid to descend and lingual thyroid is usually all the thyroid the patient has. A tracer dose of radioactive iodine may be helpful in determining the nature of such a tumor if lingual thyroid is suspected. Unless it is causing symptoms or showing progressive growth or unless induration is present suggestive of malignant change, removal of the lingual thyroid is not indicated.

If the tumor is in the thyroid region the most likely possibility is thyroid origin, of course. Movement of the tumor when the patient swallows is an aid in establishing the thyroid origin of a tumor. Exact clinical diagnosis of tumors of the thyroid is difficult because there is no certain clinical distinguishing characteristic between adenoma and early carcinoma. This point has been repeatedly emphasized in the medical literature and our own experience has confirmed it. The fact that one cannot be sure about a thyroid tumor makes it necessary in most cases to go ahead with the removal of it. If carcinoma is found at least a hemithyroidectomy should be done and the opposite lobe should be very carefully explored. When metastases are present in the neck, a radical neck dissection should supplement the thyroidectomy and the thyroid and lymph node bearing tissue should be removed en bloc together with the sternocleidomastoid muscle and the internal jugular vein.

Behind the angle of the mandible and just anterior to the ear, tumors of the parotid should be suspected (Figs. 8 and 9). These may be adenomas, mixed tumors, carcinomas, or cystadenoma lymphomatosum also called Warthin's tumor. Obstruction of the parotid duct by calculus may at times result in enlargement of the parotid gland which may simulate a true tumor. As a rule the history of variation in size and of increase coincident with ingestion of food is enough to make the distinction clear. An inflammatory process in the parotid gland carries along with it other symptoms of acute inflammation which usually prevent confusion with a true neoplastic process. Salivary gland tumors can also arise in the submaxillary gland and rarely in the submental salivary gland.

In the region of the bifurcation of the common carotid artery, tumors can be present which may be found to be cystic and which are of branchial cleft origin (Fig. 10). Theoretically these can occur anywhere in the anatomic distribution of the branchial clefts, but as a rule the ones most frequently seen are just below the posterior part of the submaxillary triangle at the level of the bifurcation of the carotid artery. Branchiogenic cysts are usually benign. They extend deeply into the neck and must be excised with care for they are in close approximation to the internal jugular vein, the carotid artery and the hypo-



Figure 7. Thyroglossal cyst.

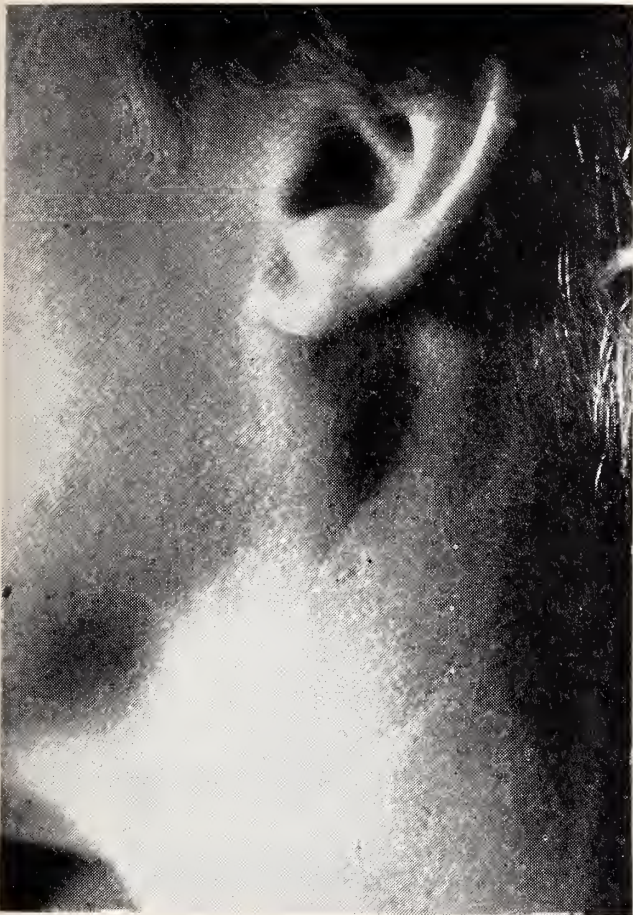


Figure 8. Mixed tumor of parotid.

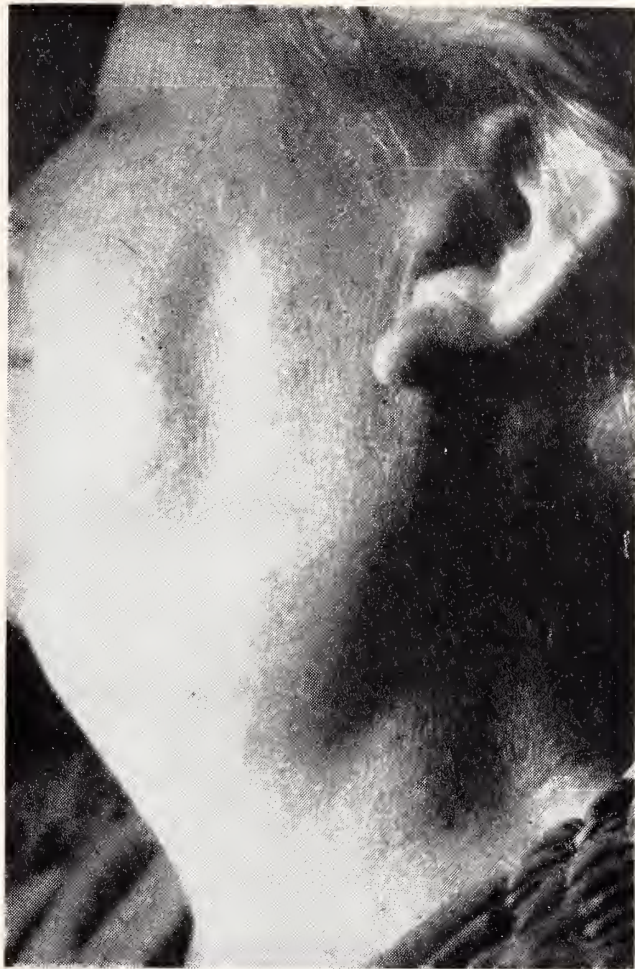


Figure 10. Branchial cleft cyst.



Figure 9. Carcinoma of parotid.

glossal nerve. The development of carcinoma in a branchiogenic cyst is exceedingly rare. Nearly every carcinoma in this area eventually turns out to be metastatic rather than primary.

In this same general area centered about the bifurcation of the carotid artery and arising from a deposit of chromaffin tissue at the bifurcation, carotid body tumors can occur. These are rare and the diagnosis is usually not made until metastatic carcinoma can be definitely excluded. Aspiration biopsy may be helpful. The textbook sign of diminished mobility in a vertical plane and free mobility in a lateral plane cannot always be clinically demonstrated. Carotid body tumors are usually quite firm and non-tender, they tend to grow slowly and as a rule have been present for several years before the patient comes in for examination. They may be confused with metastatic carcinoma involving the lymph nodes at the bifurcation of the common carotid artery and they occur at about the same point in the neck as do branchial cleft cysts with which they can also be confused. Carotid body tumors seldom become malignant and it is best to leave the tumor in place if ligation of the common or internal carotid

Let's Hear the AMA President

The Association is honored to have Louis H. Bauer, President of the American Medical Association, who will speak to the House of Delegates on the subject "Today's Challenge to Medicine." His talk is scheduled at 2:00 p.m., Sunday afternoon, May 10.

arteries is essential to its removal, since the hazard of ligation of these structures is great, the reported mortality being between 30 and 50 per cent. Sometimes rather prominent arterial pulsation can be felt in the tumor causing one to consider the possibility of an aneurysm. The pulsation, however, is partly due to the fact that the tumor is in such close contact with the carotid artery and partly due to extreme vascularity of the tumor. One point that may help in distinguishing a carotid body tumor from a branchiogenic cyst is that the carotid body tumor tends to enlarge inward and can sometimes be felt by a finger placed along the pharyngeal wall. Branchiogenic cysts tend to enlarge outwardly and are more readily visible externally.

The tumors of lymphatic origin most frequently seen in the neck are Hodgkin's disease, lymphocytic lymphoma and reticulum cell lymphosarcoma. In rare instances these may be confined to the neck but as a rule they are a manifestation of a generalized disease and lymph adenopathy elsewhere with or without splenomegaly may help to clarify diagnosis. Lymphomas in the neck can be confused with metastatic carcinoma, with parotid tumors, and with tuberculous lymphadenitis. Usually lymphomas are somewhat less indurated than is metastatic carcinoma. Aspiration biopsy may be helpful in determining the type of tissue present but may not make a definite diagnosis possible. If lymphoid tissue is secured on aspiration, excision of a lymph node is in order to establish the diagnosis. There is some evidence that a single solitary lymphoma can be effectively treated surgically but this type of lymphoma is very rare, and, as a rule radiation therapy is almost always the treatment of choice.

Tumors which arise from nerve, such as neurofibroma and neurogenic sarcoma can be primary in the neck but are rather infrequently seen. Another tissue of origin is fat. Lipomas are fairly common but malignant tumors of fat origin such as liposarcoma are not, although they have occurred.

Lymphangiomas, also called a cystic hygroma, may arise in the neck. Although it is more frequent in infants, it is occasionally seen in adults and we have a proven case in a woman 75 years of age. Lymphangiomas are apt to extend rather widely but can be removed by a prolonged and careful dissection. Hemangiomas occasionally occur in the neck

but they are relatively infrequent and usually are present in infants. Another tumor which should be mentioned is the sebaceous cyst. It is frequently looked upon as an entirely benign lesion, yet we have seen cases in which fully malignant squamous carcinoma has arisen in a sebaceous cyst in the neck. It of course may be located anywhere in the superficial portion of the neck and has its origin in the sebaceous glands of the skin.

Treatment for benign tumors is careful, complete local excision. This may be done under either local or general anesthesia depending upon the location and extent of the tumor. If the tumor is malignant and primary in the neck, complete excision is again the treatment of choice and if lymph nodes are involved it should be accompanied by a radical neck dissection. Although surgery is the treatment of choice in thyroid cancer, radioactive iodine may be helpful in advanced or recurrent disease. It at times may cause regression of distant metastases. If the tumor is due to a lymphoma, X-ray therapy is the indicated treatment with the possible rare exception of a completely localized lymphoma in which excision may be considered, supplemented by postoperative X-ray therapy. We do not use postoperative X-ray therapy after radical neck dissection unless there is doubt as to the complete surgical removal of the carcinoma.

If the tumor in the neck is metastatic carcinoma, the primary lesion should be found and should be controlled or controllable before the disease in the neck is attacked. Choice of irradiation or surgery for the primary lesion depends upon the nature and location of the growth and is not within the scope of this paper. It is generally agreed that metastatic carcinoma of the neck can best be eradicated by radical neck dissection. At times removal of the primary tumor in continuity with the bloc dissection of the neck can be carried out. Benign tumors are best treated by careful excision. For operative procedures on the neck we have found intravenous pentothal anesthesia with oxygen supplied through an intratracheal tube to be most satisfactory. If this is used the neck can be turned to facilitate greatest exposure without danger of impairing the airway and long operative procedures can be carried out without hazard to the patient provided care is taken to control all bleeding points and to so plan the approach that there is good exposure at all times.

Summary

A tumor of the neck should be considered metastatic carcinoma until proved otherwise. The primary lesion is sometimes obscure but a knowledge of the distribution of the lymphatics in the head and neck is very helpful in guiding one to the probable location of the primary lesion. Another aid is the type of cell making up the tumor and this can often be determined by aspiration biopsy. In planning treatment the primary tumor should be controlled or controllable before metastatic disease in the neck is removed by radical neck dissection. Certain tumors are primary in the neck. These are best treated by careful and complete surgical excision.

CAR WINDOW FRACTURES

C

ar window" fractures of the left elbow, often referred to as "side-swipe" fractures, are those injuries sustained while the elbow is protruding from an automobile car window and the most common site is the left elbow of the driver. These are usually the results of trauma caused by an automobile going in the opposite direction. However, in some instances the injury results from children resting their arms outside the school bus windows, car windows, (other than the driver's) or windows of similar vehicles.

How can these disabling injuries be prevented? Probably the best method is to educate car drivers and passengers not to rest their arms on the car window ledges and to train children not to play waving and flagging their arms out of the car window.

Recently, while driving on a main highway over a hundred mile stretch, it was noted that 87 per cent of the drivers drove with part of their left arm protruding from the car window. It was further noted that 24 per cent of the cars with children as occupants were either waving their hands, arms or some other article out of the window. Only about one-third of these were on the left side, but it is almost as dangerous to protrude on the right side as on the left.

There is no definite pattern or uniformity in the nature of the car window fractures and except for the severity of the disability, there is no similarity to the cases. They range from a simple fracture to complete traumatic amputation of the left arm at the middle third. They include compound fractures of both bones of the forearm, compound fractures of the humerus, comminuted fracture dislocation of the elbow, compound Monteggia's fractures, and complete avulsion of the elbow joint including the lower third of the humerus and the proximal portion of the ulna and the radius.

The cases reviewed are from the service of the University Hospital in Augusta admitted between July 1, 1948 to June 30, 1951. There were only 20 cases proven to be injuries received while the arm was protruding from the car window. However, in several of these, the injury to the left upper extremity was not the only injury, but in many instances it was much more disabling. Thirteen out of the 20 cases were compound wounds. The description of these usually included a compound comminuted fracture dislocation of the elbow with maceration and avulsion of soft tissue. The average hospital stay for

LEFT ELBOW

the initial visit was three weeks but was noted to range from only a few days to eight weeks. Most of the patients receiving the worst injuries required six to eight weeks, and several of these required more than one period of hospitalization.

To impress the severity of these long and costly hospitalizations with disabling injuries, three case histories are presented.

REPORT OF CASES

Case No. 1: L. D., a 33-year-old colored male admitted 5-28-50 and dismissed 7-21-50, received a compound fracture both bones middle third of the left forearm in an automobile accident while his arm protruded from the left window. The wound was debrided, the arm placed in skeletal traction and chemotherapy administered. The arm was placed in a cast and the patient dismissed to return to the out patient department at which time he was readmitted and operated on again. A sequestrectomy of both bones of the forearm was done and he was followed in out patient clinic again. The patient was readmitted and had an open reduction using intramedullary fixation with Steinman pins and an iliac bone graft. The last pin was removed in February, 1952.

Case No. 2: J. B. Q., a 25-year-old colored male received an avulsion of the left elbow joint in an automobile accident with his left arm out of the car window. The soft tissue was debrided and the radius was immobilized with an intramedullary Steinman pin. The patient has no elbow joint and there has been regeneration of part of the lower portion of the humerus. He has had several fractures of the regenerated bone and has been wearing a cast, off and on since the injury in August 1950. There was considered the possibility of an osteotomy of the distal end of this new bone to encourage a pseudoarthrosis for a joint. Recently this patient was observed driving a car again with his left arm in a cast, protruding out of the left window.

Case No. 3: T. B., a 42-year-old white male, received a complete traumatic amputation at the middle third of the left arm. This man was driving with his left arm out of his car window when he struck a truck which caused complete avulsion of the arm. This required simple debridement and closure of the skin flaps. However, the disability was considerable.

Summary

In the treatment of such injuries, the first aim is prevention and this is best carried out by educating the layman. In the compounded wounds, the treatment of shock is of primary importance. Secondly, a thorough debridement and wound irrigation, with the administration tetanus antitoxin and chemotherapy. Thirdly, restoration of the elbow joint and reduction of the fractures of the long bones. Quite often this is best obtained with some form of intramedullary fixation. At times bone screws are very beneficial in maintaining position of comminuted fragments. A hanging cast is indicated in treating fractures of the humerus instead of open reduction.

Read before the Section on Industrial Surgery and Trauma at the One Hundred Second Annual Session of the Medical Association of Georgia, May 14, 1952.

CONSTRICTION

RING DYSTOCIA: *Report of Two Cases*

Rather Intensively Studied Among 17,000 Labors

RICHARD TORPIN, M.D., Augusta

According to Rucker¹ "constriction ring dystocia is that form of soft part dystocia characterized by the formation within the uterus of one or more bands of uterine muscle. These bands form opposite depression of the fetal ovoid and may occur at any level. The band may entirely encircle the fetus or may extend only partially around the fetus, but in either case, so long as the ring lasts, the fetus is effectively anchored to the uterus, and there is no further progress in birth in spite of painful uterine contractions. A constriction ring (or contraction ring) is not a Bandl's ring. Bandl's ring is an anatomic concept. It is located at the junction of the active contractile portion of the uterus with the lower uterine segment. As is well known, Bandl's ring ascends in obstructed labor, and the lower uterine segment becomes thinner and may eventually rupture. On the other hand, a constriction ring does not rise, but remains fixed to the fetus, and spontaneous rupture of the uterus does not occur. On account of the confusion in terminology, Rudolph suggested that the term constriction ring be revived. A constriction ring may be reversible or irreversible."

CASE REPORTS

Case 1. S.P., obese negro female, aged 26, gravida 7, para 5, one set of twins (of which one died at three months of age) and one five months' spontaneous abortion, has five living children. Her menstruation began at 12 years of age and continued with regular 28 day cycle and duration of five days. She was near term, having had some headache and dependent edema. Her membranes ruptured spontaneously and the umbilical cord prolapsed 50 hours later. The family physician, on vaginal examination that afternoon, found the right hand presenting and attempted, but failed, to do a version, then sent her to the hospital. The fetus was in transverse presentation, head to the right, spine up, breech to left. No fetal heart sounds were audible, nor was there cord pulsation. There had been no labor pains noted by the patient. Her blood study revealed 11.6 gms. hemoglobin and 4,070,000 R.B.C. The urine was normal, B.P. 132/85, T. 102.2, P. 90, R. 26. No vaginal examination was made. She was put on hydration and vitamin therapy, sulfadiazine and

a 7 lb. weight traction applied to the hand, with 45 seconds on and 2 minutes off, for 24 hours. This incited rather poor labor pains every 2-3 minutes, but the arm came down no more than 2 cm. above the elbow at the introitus.

During the following day she stated that she felt well, but appeared quite ill, with T. 104, P. 130 at 4 p. m., 2-23-45. A few hours later she was prepared for sterile vaginal examination, at which time it was found that the cervix was 2/3 to 3/4 dilated. Approximately 8 cm. above the dilated and flaccid external os was a constriction ring of the lowermost part of the upper uterine segment encircling the upper part of the arm which prevented further descent of the shoulder. This ring was approximately 15 mm. from top to bottom and 8 cm. in internal diameter, with uniformity all around. It did not change during the examination, which was conducted under deep ether anesthesia. She was then allowed to recover from the anesthesia. Oxygen had been administered for several hours because of the rapid pulse rate. Further conservative therapy was continued; traction to the arm as before, morphine sulfate one-fourth gr., and hyoscine 1/100 gr. subcutaneously. Five per cent dextrose solution with sodium nicotinate 100 mgm., and thiamine chloride 20 mgm. per 1,000 cc. was continued. Six hours later, and without much evidence of progressive labor in the intervening time, she was again examined as before, under ether administered to the degree adequate for internal version. Again, there was no change in the state of affairs, except possibly almost full dilation of the cervix, through which a hand could easily be inserted alongside the protruding fetal arm. The constriction ring was exactly as before, with same fixed rigidity and too restricted in diameter (8 cm.) to permit version of the dead fetal body, which was rather tightly held by the remainder of the fundal wall. We were, however, able to decapitate the fetus by a previously described piano wire method², and without excessive traction on the arm, the body of the near term fetus slipped through the constriction ring and was delivered. The head, approximately 9.5 cm. in B.P. diameter, was too large to pass, even with so much traction on the lower jaw that it was pulled off. On advice of Robert Woodbury, Professor of Pharmacology, and based upon Rucker's work, 1/2 cc. of 1/1000 Epinephrine solution was given subcutaneously with the idea it would be effective within five to 10 minutes. At the end of the longer time there was no change in the ring, and it was decided to remove the uterus rather than to continue the previous unsuccessful regime. The operating room was quickly set up so that she would not be too long under the anesthetic and laparotomy done. The ovarian arteries had just been ligated when it was noted that the fetal head and the placenta had been spontaneously expelled from the vagina. Very likely, the blood supply to the uterus would have been quite adequate, but

Read before Section on Obstetrics and Gynecology at the One Hundred Second Annual Session of the Medical Association of Georgia, May 14, 1952.

From the Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta.

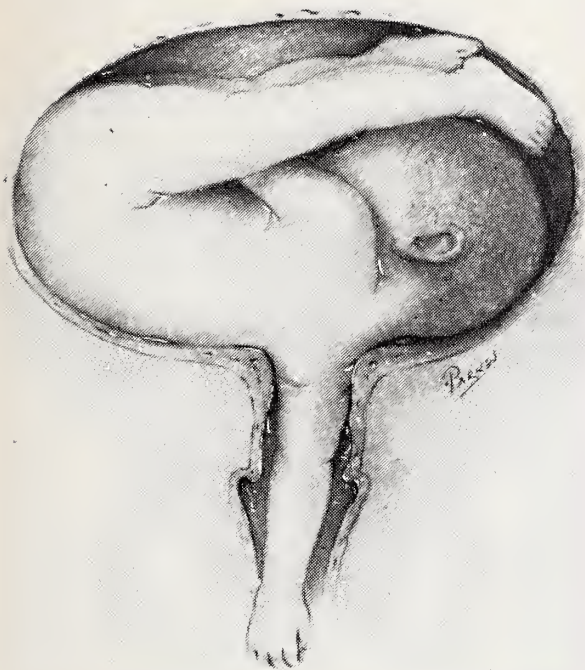


Figure 1. Drawing depicting condition found in Case 2.

because of some question in this respect, the fundus was then removed by subtotal hysterectomy. As was the practice at that time, sulfanilamide and penicillin were placed in the lower abdominal cavity and the abdominal wound layer closed with no drains. The patient recovered without particular difficulty and has been well since. The uterus grossly appeared to be normal and like other normal puerperal uteri. There was no evidence of a ring or of trauma to the uterine wall at its previous site, in spite of the possibility that the constriction ring had been present for 4-5 days, and excessive pressure had been exerted upon it.

Case 2. P.J., negro female, median to obese constitutional type, aged 23, para IV, gravida V, entered the maternity shelter at 11:15 a.m., Wednesday, January 16, 1952. She stated that she had a few pains Saturday and Sunday evening, with none on Monday. They began again Tuesday night, but ceased when she went to bed. They occurred again at 7:30 a.m. on the day of admission. She was apparently in the second stage of labor, with the membranes presenting and bulging at the vulva. The students on duty put her on the delivery table and called the resident, who noted an arm in the vagina and also diagnosed the presentation as transverse. The membranes ruptured spontaneously while on the table. She was then transported across the way to the hospital, where x-ray films were quickly made, to wit: lateral soft tissue and flat film. These revealed that the fetal head was to the left and breech to the right, with the back downward and the posterior (right) arm extended into the vagina down to the introitus. From the x-ray room, 12:15, she was taken immediately to the delivery room where, under general anesthetic (cyclopropane), she was sterile examined. We were surprised to find that, while the cervix was fully dilated, there was a distinct constriction of the uterine canal estimated to be a centimeter and one half long with the greatest constriction approximately 7 or 8 cm. above the external os. The internal diameter was about 4 or 5 cm., and through it came the right arm to the shoulder. A still more amazing fact, confirmed by several residents, was that this muscular constriction relaxed after a minute or so of contraction to a diameter of about 8 cm., but at intervals of 5 minutes or thereabouts, it resumed its contracted state which stayed on

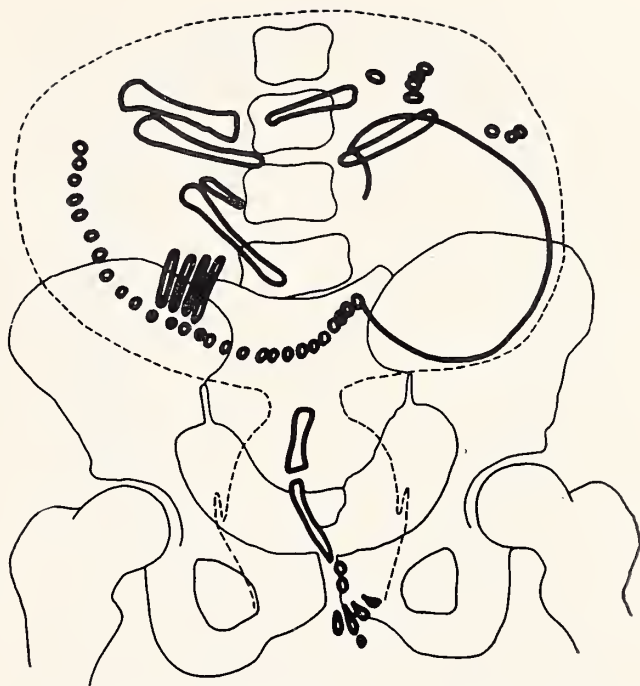


Figure 2. Skiagram of anteroposterior x-ray film of patient in Case 2.



Figure 3. Skiagram of lateral x-ray film of patient in Case 2.

approximately one minute. Any movement of the examining fingers in the canal tended to cause contraction. During the relaxed state one could reach up high enough to palpate the fetal ribs and even encircle the neck, but at no time during palpation, over a period of 35 minutes under anesthesia, was there much other change. The cyclopropane was replaced by ether to respiratory arrest during this time and also epinephrine one-half ampoule subcutaneously was administered and the ring observed by gentle palpation without attempt to irritate it over a period of 20 minutes. There was no effect

from the epinephrine or from the deep ether anesthesia administered by one who is familiar with the depth necessary for internal version. As to the remainder of the fundus above the ring, it seemed to be fairly firm, but not enough to cause asphyxia of the fetus whose heart rate was quite normal at the end of the examination. No definite contractions of this portion of the uterus were noted, although there was pushing down of the fetus against the constricted area when the patient retched during time of change of anesthetic from cyclopropane to ether. Not wishing to deliberately destroy the living fetus and feeling quite certain that no amount of manual dexterity would suffice to deliver even a dead fetus vaginally unless marked changes in the birth canal could be effected, we decided to complete the labor by cesarean section, which was done immediately after replacing the arm above the ring and sterile packing the vagina in a near-by operating room. Laparotrachelotomy was done with transverse incision approximately 4 cm. above the external os. This, however, was a bad choice compared with classical section in this particular instance, inasmuch as the muscular ring had not in the least relaxed and our transverse incision was about 4 cm. below it. Running a finger through the ring permitted opportunity to palpate the upper uterine wall. This was much more pliable and relaxed and estimated 1 cm. thick. This condition then required longitudinal incision through the ring area which was approximately one inch thick all around the uterus. The incision had to extend several centimeters above into the upper uterine segment before fetal delivery could be effected. The fetus was pallid and the heart tones were not readily perceptible, but it revived soon with tracheal insufflation of oxygen under 14 mm. mercury pressure. Inasmuch as there was extensive T incision in the uterine wall and the mother had four living children besides this one, the uterus was excised at the level of the transverse incision. The male infant, weigh 5 lbs. 4 oz. did so well that it was not put into the special premature room. On the fourth day it developed infection around the umbilicus, temperature 105, and succumbed. No doubt, the cord became infected during the manipulation for resuscitation. The postpartum uterus weighed 1,174 gms. The wall immediately above the internal os was approximately 30 mm. thick at all areas of the circumference. The fundal wall now contracted was in the neighborhood of 20 mm. thick. The placenta, discoid and total marginate was located entirely above the ring on the posterior wall and was 18 x 18 cm. in diameter with cord implanted centrally. The umbilical cord was 30 cm. long with counter clock twists few in number.

Exactly one year before she had entered the maternity shelter in labor, membranes having ruptured spontaneously 24 hours previously. She remained in false labor for several hours with attempts at external version, inasmuch as the presentation was transverse, head to left, breech to the right and back presenting with the placenta on posterior wall, all confirmed by anteroposterior and lateral films. This presentation and placental location exactly duplicated the present one. Being unable to effect external version and fearing prolapse of an arm, we introduced a large Voorhees bag at noon, 2-3-51. This was expelled at 6 p.m. and immediately deep ether anesthetic administered, and internal version done by grasping the feet under the liver and sweeping them to the left and down, followed by extraction. The fetus, male, weight 7 lbs. 9 oz., required 45 minutes of intratracheal insufflation with pressure controlled to maximum of 14 mm. Hg. (20 cm. water) and now is apparently normal. There was a laceration of the cervix which was sutured and no evidence of a scar was noted at this delivery. Her other three previous children were normal, spontaneous cephalic deliveries and are living and well.

While the etiology of Bandl's retraction ring, when of a pathologic type, is exhausting labor, that of constriction ring, first well described by Clifford White^{3 4 5}, is certainly functional in nature, either myogenic or neurogenic. Since this is the case, it, theoretically in all cases, should be subject to drug relaxation. In the literature of the past 75 years on the subject specific instances of the disorder have

been well observed and many types of therapy studied. Gilliatt⁶ credits Barnes with the first use of amyl nitrite by inhalation. In reference to this drug he states; "Amyl nitrite by inhalation was first used by Barnes, as long ago as 1881, in the treatment of hour-glass contraction of the uterus in the third stage of labour. Souter used it to restore a patient who had been given too much chloroform in dealing with her contraction ring. An attempt to deliver with the forceps had failed, but directly after the use of 10 minims of amyl nitrite, delivery was easily effected. Souter also describes a second case in which it was used successfully. Croft has published a successful case using minims vi. In one of my cases (No. 14) minims iii were given with magical effect, and I feel sure it is worthy of use in all cases in which the cervix is sufficiently dilated to enable delivery to be completed if relaxation of the ring can be obtained, and also in cases of hour-glass contraction during the third stage of labour."

In 1925 Rucker⁷ noted that with the use of sacral anesthesia in labor with novocaine 1.5 per cent solution there frequently, but not always, followed a diminution, or a complete cessation of all contractions for a period of time varying from 20 to 75 minutes. He then attempted to account for this variability in uterine action and discovered that when the usual addition of epinephrine was omitted, the contractions of the uterus were not abated. At that time, it was held that epinephrine caused increased contractions. He then proceeded to test its effect upon the laboring uterus of 20 patients, administering five minims of one to 1000 solution of adrenalin subcutaneously. In regard to this study he stated; "of the 20 patients, 16 showed a prompt cessation or a diminution in the strength of the uterine contractions for nine to 30 minutes after a hypodermic administration of five minims of adrenalin. In four cases there was no demonstrable effect. In no case was there an increase in the force or frequency of the uterine contractions." Woodbury and Abreu⁸ have more recently elaborated upon this inhibitor effect of epinephrine when administered by the hypodermic route. Taking advantage of this discovery, Rucker⁹ then used this drug in constriction ring dystocia with almost complete success, and the method has been adopted rather uniformly among American obstetricians. It should be administered subcutaneously in one-half ampoule doses, of one to 1000 solution and it ought to act within five to 10 minutes, but, as noted in case I here reported, its dramatic effect was delayed for 25 minutes. Epinephrine may be used in patients anesthetized by ether, but it is said to possess dangerous cardiac effects tending to produce fibrillation if combined with cyclopropane or chloroform.

Since there were only two cases of this condition in 17,000 labors managed directly or through residents who immediately reported any abnormalities, it may be concluded that the type of labor management in these cases may have been of aid in preventing the development of a constriction ring. Briefly, this management has been directed to



Figure 4. After Clifford White 1916. Uterus with constriction ring. The lower uterine segment is not thinned, the fundus is frequently relaxed, and the ring forms over a depression in outline of the fetus.



Figure 5. After Clifford White 1916. Uterus with pathologic retraction ring (Bandl). The lower uterine segment is thinned, the fundus tonically contracted, and the ring forms at the junction of the thickened upper and thinned lower uterine segments.

early recognition of any type of obstructive labor and to maintenance of the action of the uterus in normal labor contractions. If other types, as false labor or dystocia dystrophica began to intervene, the uterine contractions were abolished or returned to normal action by magnesium sulfate intravenously in one gram doses or by morphine sulfate in one-fourth grain doses subcutaneously. The most important feature of the uterus in labor is its internal pressure during relaxation between contractions. This must return to a normal of five mm. mercury or thereabouts. If the uterus remains firm between contractions magnesium and/or morphine are indicated to cause relaxation. Furthermore, hydration was maintained at all times by .5 per cent dextrose solution, at least 3,000 cc daily, if fluids by mouth were not indicated. Oxygen was administered by nasal tube when any exhaustion of mother or fetus was evident. Oxytocics were not used. Blood transfusions were given if the hemoglobin was less than 10 gms. per 100 cc.

Inasmuch as the literature of constriction ring is confused by more theory than fact, each new case should be thoroughly studied with the idea of reporting the characteristics including size, location, etc. This is possible because the uterus with constriction ring does not tend to rupture. The diagnosis by sterile intrauterine palpation should be made relatively early in suspected cases. All of the known and accepted methods of relaxation may be successively employed. The two most successful in the past have been amyl nitrite and epinephrine. Others may be found in the future. After the vaginal diagnosis with recording of the length, internal diameter, site, etc., amyl nitrite, 3-5 minims, inhaled by the patient, may have dramatic effect in relaxing the ring almost immediately. In case amyl nitrite fails, one might wait 15 or 20

minutes and then administer epinephrine subcutaneously in one-half ampoule dose, which may be repeated. Relaxation, if successful, occurs usually within five or 10 minutes, but may be delayed 30 minutes. All instances should be reported in the medical literature. One such well detailed case report is often much more valuable than many pages of unsupported theory.

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DISCUSSION

DR. EVELYN SWILLING (Macon): Dr. Torpin has refreshed us with the differential points between Bandl's ring and constriction ring, and has given us two case reports.

Two cases of constriction ring dystocia out of 17,000 cases is positive evidence of good labor management in the obstetrical department at the Medical College of Georgia.

The maintenance of normal uterine action by proper hydration, adequate rest, oxygen and blood, and the early recognition of obstructive labor, are invaluable in the prevention of constriction ring.

I hope that in the future we have more case reports on constriction ring, so that we may further learn about the management of such cases.

Residual TYPHUS Fever in

GEORGIA

HENRY GREENE, M.P.H., and

J. E. McCROAN, JR., Ph.D., Atlanta

The decline in the incidence of typhus fever in Georgia during recent years has raised a question as to the possibility of completely eradicating the disease. Since the infection is well established in an abundant host, the domestic rat, eradication offers practical difficulties. Nevertheless, the possibility is sufficiently real to deserve serious consideration, and the purpose of this paper is to evaluate the situation as it exists today.

Murine or endemic typhus fever was first described in 1913 by the late Dr. James E. Paullin of Atlanta. The disease has often been referred to as Brill's disease although it is now believed that the entity described by Brill in New York was actually a recrudesence of classical louse-borne typhus occurring among immigrants from Europe who had previously suffered from the disease in their native lands.

From the date of Paullin's report until 1930, the incidence of typhus fever in Georgia remained at a comparatively low level. Then an upward trend began and continued until 1937 when 1092 cases were reported. Thereafter, with one exception, the disease remained at about the same yearly level through 1945. Since then it has declined steadily.

In 1937 a typhus control program was organized by the Department of Public Health. The earliest measures employed to combat the disease consisted chiefly of rat eradication, rat proofing of buildings, and promoting community projects for better refuse collection and disposal. These measures were effective in local areas but the number of communities which participated in the program was too small to greatly affect the incidence of the disease in the state as a whole.

In 1945 DDT insecticide dust became available and with the assistance of federal funds, a greatly expanded control program was possible. The application of DDT dust to rat runs, harborages and burrows was aimed directly at the principal vector, the

From the Georgia Department of Public Health.

Indian rat flea (*Xenopsylla cheopis*), for the purpose of preventing the spread of infection from rat to rat and from rat to man.

The success of this phase of the program is indicated by the decline in the number of human infections and by a significant drop in the percentage of rat bloods showing murine typhus fever antibodies. As shown in Table 1, the number of reported human cases dropped from 1111 in 1945 to 58 in 1951 and a corresponding decrease was observed in the percentage of rat bloods showing antibodies.

The decline in the number of human cases afforded an opportunity to concentrate a major portion of the control effort on destruction of the domestic rat. At the same time, the effectiveness of this phase of the program was greatly enhanced by the introduction of a new rodenticide, Warfarin. While other rodenticides have been employed with good effect in the past, all have serious disadvantages. Some are too toxic for indiscriminate use around human habitations while others quickly induce bait shyness in rats. With the advent of Warfarin, an anti-coagulant first developed by the Wisconsin Alumni Research Foundation, the possibility of successful rodenticide campaigns was greatly enhanced. Not only is Warfarin an effective rodenticide, it is relatively safe for man and large animals because it must be ingested on several successive days to produce toxic effects. Even in rats no kill should be expected before the fourth or fifth day.

The typhus carriers common to Georgia are the brown rat (*Rattus rattus norvegicus*), the black rat (*Rattus rattus rattus*), and the roof rat (*Rattus rattus alexandrinus*). These species as well as mice and native rodents react to Warfarin without apparent bait shyness when 0.5 per cent powder is mixed with a diluent like yellow corn meal in the amount of 19 parts of meal to one part of Warfarin. During 1951 approximately 75,000 premises were treated with satisfactory results. Warfarin was also used by com-

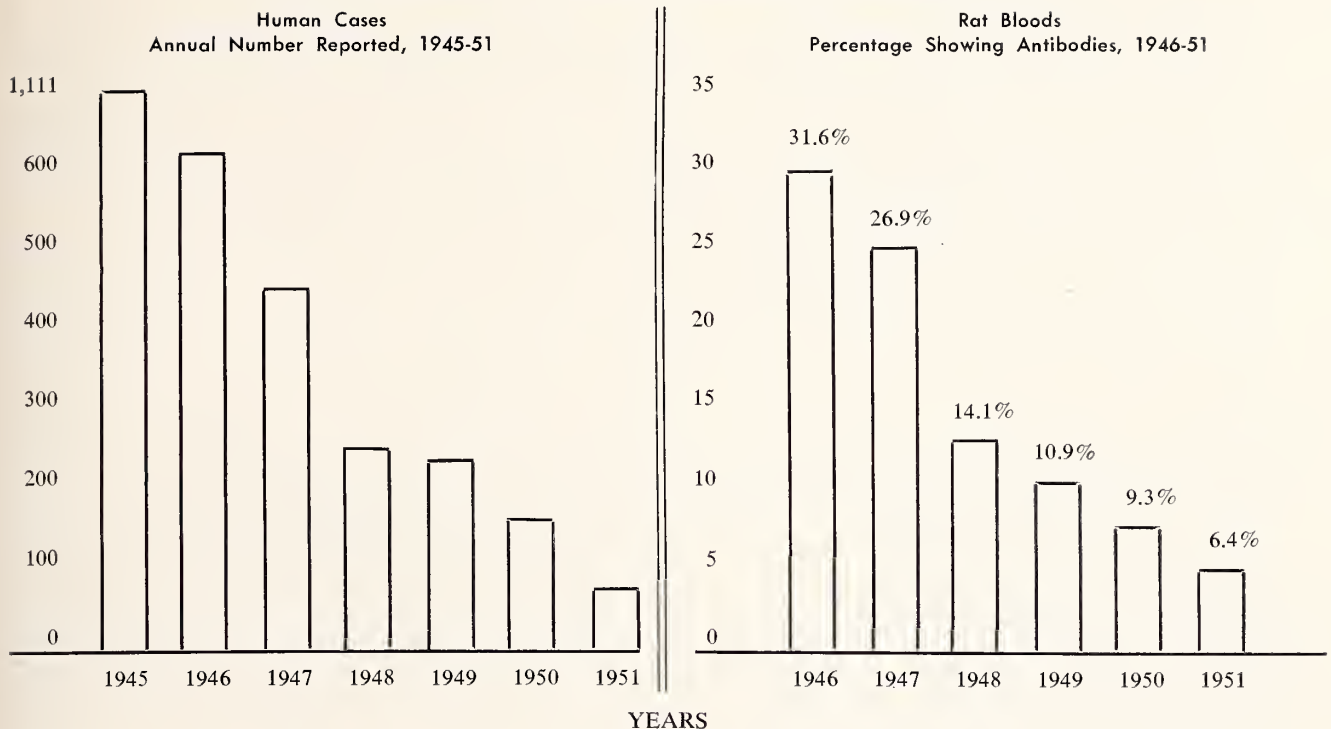
Don't Miss These Panel Discussions

An interesting Panel discussion on the topic "The Program of Vocational Rehabilitation in Georgia" is scheduled for 9:00 a.m. Monday morning, May 11.

And surely you'll want to attend the Panel discussion on "Insurance Plans and Problems in Georgia." Mark Wednesday morning, May 13, at 9:00 a.m. as the time to attend the Insurance panel.

TABLE I

Murine Typhus Fever in Georgia—Human Cases vs. Rat Infections



mercial pest control operators and by an increasing number of householders and farmers. Particularly in isolated areas, it has been possible through the use of this rodenticide to reduce the rat population to insignificant levels.

Since rats move about with relative facility, extermination in a localized area is soon followed by migration in from some adjacent area. Therefore, re-applications of Warfarin are required from time to time in order to maintain control. However, no signs of developing bait shyness or resistance have been noted thus far and control can apparently be maintained for indefinite periods.

Another effective typhus control measure is the promotion of municipal refuse collection and sanitary landfill disposal projects. Since the size of a rodent population in a given area is limited by the amount of available food and shelter, the elimination of rat harborages and food sources is promptly followed by a drastic reduction in the number of rodents. During recent years, approximately 30 cities and towns in Georgia have discontinued open dumping practices.

The dusting of premises with DDT continues to be employed wherever the occurrence of human cases justifies its use. For the purpose of locating infected areas, knowledge of the existence of human infections is of prime importance. Unfortunately, the reporting of typhus fever has been affected by the rapidity with which the disease can be brought under control with modern treatment.

Since the Weil-Felix reaction and, especially, the

complement fixation reaction may be delayed or modified by antibiotic therapy, the collection of convalescent bloods on all suspicious cases is very important for diagnostic purposes. It is also very helpful for the laboratory to have an earlier specimen to compare with the convalescent blood. When this is possible, even a moderate rise in titer may be considered significant.

Differentiation between typhus and certain other febrile illnesses is highly desirable in view of the control problems involved. As an example, one might consider typhus and Rocky Mountain spotted fever which usually respond alike to antibiotic therapy and react in an almost identical manner in the Weil-Felix test. The two diseases can be finally differentiated only on the basis of complement fixation tests on convalescent sera. Nevertheless, the epidemiology and control of the two diseases are dissimilar in important respects for the tick vector

Topflight Symposia Scheduled

Outstanding Symposia on the Annual Session program highlight each day's activity. Let's not miss any of these features. The subjects, time and dates are as follows: "Symposium on Gastroenterology" at 9:00 a.m. Tuesday morning, May 11; "Symposium on Orthopedics and Trauma" at 9:00 a.m. Tuesday morning, May 11; and "Symposium on Burns" at 2:00 p.m. Tuesday afternoon, May 11.

Public Meeting—Open to All

At an Open Public Meeting sponsored by the MAG Auxiliary, Mr. Arthur L. Conrad, of Chicago, will deliver an important address on topic "Are We Educating or Indoctrinating Our Children?" Mr. Conrad, President of The Heritage Foundation, has a background of experience that makes him an authority on this subject. The time for the address is 4:30 p.m., Sunday afternoon, May 10. As this is a meeting the public is also invited to attend—be sure to be there on time.

Another Highlight—The Abner W. Calhoun Lecture

Cyrus C. Sturgis, of Ann Arbor, Michigan, Professor of Internal Medicine and Chairman of the Department of Internal Medicine at the University of Michigan will deliver the Abner W. Calhoun Lecture. His subject will be "Some Recent Advances in Hematology." It is scheduled on your Annual Session program for 12:00 p.m., Tuesday, May 12.

of Rocky Mountain spotted fever is apparently also the reservoir host.

Another example is leptospirosis. In the light of recent knowledge concerning human leptospiral infections, most of which do not give rise to jaundice, it is apparent that sporadic cases of this disease may at times be suspected of being typhus infections which did not respond promptly to antibiotic therapy. Here again, reliance on laboratory aids for diagnostic purposes becomes increasingly important.

The demonstrated effectiveness of the control measures described above has given rise to the hope that typhus fever may be completely eradicated. It seems entirely possible to break the chain of transmission from one rat group to another and confine the disease to ever shrinking islands of infection. As with other diseases dependent on a complicated host-parasite relationship for existence, the process of transmission becomes more and more difficult and precarious as the number of infected and/or susceptible individuals declines. Since rats remain infective for their ectoparasites for varying but limited periods of time, it is apparent that in any given locality some minimum number of rats is required to permit continued transmission of the infection. Thus, when that critical level is passed, it is probable that the disease will rapidly disappear just as native malaria has disappeared.

In summary, the elimination of typhus fever will not involve complete eradication of the domestic rat. There is good reason to believe that the infection will disappear when the rodent population reaches a certain critical level. The means for achieving that objective now appear to be at hand.

"SEE YOU IN SAVANNAH"

THE 10-13 OF MAY

Medical Association of Georgia

103rd Annual Session at Savannah

Report: Special Session of the

AMA HOUSE of DELEGATES

March 14, 1953, will become a date of particular significance in the history of American medicine. It will be a milestone in our progress for better health for the people of America. On this date, at 10 a. m., in the historic city of Washington, D. C., the House of Delegates of the American Medical Association met in a special session. This was the fourth time that a special session of the House of Delegates has been called in the 106 years of the existence of the A.M.A. The purpose of this special session was to consider the President's of the United States proposal to Congress to reorganize the Federal Security Agency to a cabinet status.

The reorganization would provide for special assistants to the Secretary—now the Federal Security Administrator—for Health, Education, and Welfare. The special assistant for Health would be a M.D.; one recognized as a leader in the medical field with non-governmental experience. His specific duties shall be: (1) "top staff policy adviser to the Secretary on health," (2) "see that health and medical problems arising within the Department" are "properly coordinated," (3) represent the Secretary on top level government committees, and (4) be the Secretary's liaison with international and domestic professional associations, including the A.M.A. Another important change is the position of the Social Security Commissioner, which will be removed from the Civil Service and be made a Presidential appointment.

Another special feature of this meeting was the personal appearance of the President of the United States before the House of Delegates of the A.M.A. He asked the support of the medical profession and promised that they would receive his whole hearted cooperation. He stated, "I don't like the word 'compulsory,' and I am against the word 'socialized.'" He is against any force, power, or idea that leads us to forsake our traditional system of free enterprise. After the President spoke, Senator Robert A. Taft and Representative Walter H. Judd, M.D. from Minnesota, addressed the special session. They spoke in favor of the President's reorganization plan and asked the House of Delegates to support it. Taft said that the plan would serve to "build up a philosophy to protect medicine and other professions against intru-

sion of socialized medicine or anything else compulsory in the American system of free enterprise." Dr. Judd said that the reorganization plan is the only way to clean out the Federal Security Agency.

At this time the Chairman of the Board of Trustees of the A.M.A., Dr. Dwight Murray, read the recommendation of the Board and recommended that the House of Delegates reaffirm its stand in favor of an independent Department of Health, but that it support the President's Reorganization Plan No. 1 of 1953 as being a step in the right direction; that the A.M.A. cooperate in making the plan successful; and that it watch its development with great care and interest. A motion was made to accept the Board of Trustees' recommendation. After a brief discussion, a motion was made to recess until 1:30 p. m. to give the members time to study the proposal more thoroughly. At 1:30 p. m. the House of Delegates reconvened. After some debate, a substitute motion, eliminating certain phases of the Board of Trustees' recommendation was introduced. This was defeated and the House of Delegates voted unanimously to accept the Board of Trustees' recommendation in full. Dr. Louis H. Bauer, president of the A.M.A., thanked the delegates and termed this "the most constructive action of organized medicine in a long time." The House of Delegates adjourned at 2:15 p. m.

In analyzing the action of the House of Delegates, it can be said that: (1) we still stand firm for our principle for a Secretary of Health with cabinet rank; (2) this reorganization plan was going through regardless of our position; (3) by cooperating we will be in a better position to push our aims. We may have altered our position, but we have not changed our principle. There is quite a difference in principle and position. It is often necessary to change position in order to reach our goal. For the last 30 years we have had to fight a defensive battle. We have not had an entree to the White House or the Federal Security Agency. With this reorganization plan we have gained entrance. We have a chance to get our hands on the ball and assume the offensive. Let us get together and continue our fight for medicine's rightful place in the welfare of the American people.

EUSTACE A. ALLEN, M.D.

ANNOUNCEMENTS

APRIL 14: Eighth District Medical Society will meet at 2:30 p. m. in Valdosta.

APRIL 15: Ninth District Medical Society will hold its regular spring meeting at the North Georgia Trade and Vocational School, Clarkesville, on Wednesday, at 3 p. m. The following scientific papers will be presented: "Carcinoma of the Colon," "Cystic Masses of the Abdomen," and "Report of Two Cases of Congenital Atresia of the Gall Bladder." A social hour will be held at 5:00 p. m., followed by dinner at 6:00 p. m.

APRIL 16: Habersham County Medical Society will hold their monthly meeting.

APRIL 17-18: Southern Society of Anesthesiologists will meet at the Academy of Medicine, 875 West Peachtree St., N. E., Atlanta, for a two-day session beginning at 9:00 a. m.

APRIL 24-29: The American College of Allergists will hold their annual meeting at the Conrad Hilton Hotel, Chicago. For detailed information write: American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minn.

SOCIETIES

First District Medical Society, with an attendance of 116 members, met at 3:00 p. m. March 18, in Statesboro. After an address by Medical Association of Georgia President C. F. Holton and a talk by Mr. Sid Wrightsman, executive secretary of the MAG, three scientific papers were presented. Dr. Thomas McGoldrick, of Savannah, delivered a paper on "Use of Intermittent Positive Pressure Oxygen" with a demonstration. Drs. John Bardsdale, Jr., A. B. Daniel, and David Robinson, all of Statesboro, presented a paper on "Uremia Following Complete Gastric Obstruction Due to Carcinoma." "Supracondylar Fractures of the Humerus" was the paper given by Dr. Peter B. Wright, of Augusta.

Also meeting at 3:00 p. m., the Woman's Auxiliary heard an address by Mrs. Ralph Fowler, President of the MAG Auxiliary. Following these afternoon meetings, a cocktail party was held and the Dinner Banquet at 7:00 p. m. had for the guest speaker, Mr. Porter W. Carswell, of Waynesboro.

Second District Medical Society met April 2 at the American Legion Clubhouse in Albany. On the scientific program the following papers were presented: "Glaucoma," Dr. J. Mason Baird, of Atlanta; "An Outline for the Treatment of Kidney Failure," Dr. C. S. McCall, of Albany; and "Surgical Import-

Don't Miss Your Section Meeting

A list of Section Meetings are as follows:
GENERAL SURGERY, 2:00 p.m., Monday, May 11.

PEDIATRICS, 2:00 p.m., Monday, May 11.

RADIOLOGY, 2:00 p.m., Monday, May 11.

UROLOGY, 2:00 p.m., Monday, May 11.

OBSTETRICS AND GYNECOLOGY, 2:00 p.m. Wednesday, May 13.

INTERNAL MEDICINE, 2:00 p.m., Wednesday, May 13.

THORACIC DISEASES, 2:00 p.m., Wednesday, May 13.

APRIL 24: First Western Hemisphere Conference of the World Medical Association will be held at Richmond, Va. For details write: World Medical Association, 2 East 103rd St., New York 29, N. Y.

MAY 7: Fulton County Medical Society will meet at the Academy of Medicine, Atlanta. Dinner is scheduled at 6:30 p. m., followed by the scientific program at 7:30 p. m.

MAY 10-13: ONE HUNDRED THIRD ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA, SAVANNAH.

ance of the Scout Film in the Acute Abdomen," Dr. Charles H. Watt, Jr., of Thomasville. The Auxiliary joined the meeting at the dinner and social hour following the program.

Burke-Jenkins-Screven County Medical Society at their February meeting at Magnolia State Park honored Dr. Cleveland Thompson, Sr., of Waynesboro. A plaque in appreciation of his service as a past president of the MAG was presented Dr. Thompson by MAG President Dr. C. F. Holton.

Carroll-Douglas-Haralson County Medical Society met April 6 at the Tanner Memorial Hospital, Carrollton. After a 7:30 dinner, Drs. T. Reeves and C. V. VanSant, Jr., both of Carrollton, presented a scientific program on Wound Healing and Wound Disruption.

Habersham County Medical Society held their March 19 meeting at the Commercial Hotel, Cornelia. It was a combined meeting with the Auxiliary, for dinner, followed by separate business meetings. Dr. "Pep" Brown, of Gainesville, was the guest speaker, presenting a paper on "The Newer Advances in Surgery of the Stomach." The next meeting of the Society will be held on April 9.

Ware County Medical Society met in Blackshear March 5 and had as their guest speaker Dr. Hoke Wommack, Professor of Oncology, Medical College of Georgia. Dr. Wommack presented an address on "Recent Advances in Treatment of Cancer."

DEATHS

SUMNER: *Dr. Gordon S. Sumner*, 69, of Syl-
vester, died in an Atlanta hospital March 13. Dr.
Sumner, a prominent Worth County physician, was
one of the oldest practicing physicians in Southwest
Georgia. He was a graduate of the Atlanta School
of Medicine, 1906, and did post graduate work at
Tulane Medical College, 1921-22. A veteran phy-
sician, he also served the Georgia State Legislature
for 13 terms in the Senate.

VEALE: *Dr. Emory Oslin Veale*, 77, of Arnolds-
ville, died after an acute illness of a week at the
General Hospital, Athens, March 10. Graduating
from Emory University School of Medicine in 1901,
Dr. Veale practiced medicine in Arnoldsville for the
past 52 years. A native of Oconee County, Dr. Veale
was a member of the Clarke County Medical Society.

PERSONALS

Dr. Crawford Barnett, of Atlanta, recently spoke
to the Madison Kiwanis Club on the habits and
customs of the peoples of Eastern countries that he
visited on his trip abroad last year.

Dr. B. T. Beasley and *Dr. A. H. Letton*, both of
Atlanta, were re-elected officers of the 12 state
Southeastern Surgical Congress at Louisville, Ky.
Dr. Beasley was named secretary-director and Dr.
Letton was re-elected treasurer.

Dr. E. E. Butler, of Gainesville, was named as
"Man of the Year" by the Gainesville Men's Pro-
gressive Club.

Dr. Robert Collins, of Montezuma, has accepted
a three year fellowship in Surgery with the Mayo
Foundation, Rochester, Minn. Dr. Collins will begin
his work at Mayo on April 1.

Dr. Alfred Colquitt, Jr., of Marietta, recently com-
pleted a postgraduate course in gynecology at the
Harvard Medical School, Boston.

Dr. William W. Coppedge, of East Point, has been
appointed a Fellow in the American Academy of
Obstetrics and Gynecology.

Dr. Ernest E. Downing, of Newington, was hon-
ored recently with a birthday celebration given by
the people of Newington. Dr. Downing has served
the town of Newington and vicinity for the past 40
years.

Dr. Milton T. Edgerton, Jr., formerly of Atlanta,
addressed a meeting of the Georgia Association of
Johns Hopkins University Alumni at the Piedmont
Driving Club recently.

Dr. C. B. Greer, of Brunswick, was honored in

You Have a Stake in Civil Defense

Attend and hear about your stake in Civil
Defense in Georgia. "Progress in Georgia
Civil Defense Health Services" is the topic
of an address to be given by Edgar Dun-
stan, of Atlanta, at 11:40 a.m. Wednesday,
May 13. An all important subject in an era
that lives with an atom bomb as an all too
realistic threat to our civilization. And along
those lines, you'll want to hear Col. Joseph
R. Shaeffer, MC, USA, who will give an
address on "The Mass Treatment of Burns
in Atomic Warfare." Col. Shaeffer's talk is
scheduled for 2:00 p.m. Tuesday afternoon,
May 12.

March when the Brunswick Board of Education
approved the change in name of the Fourth Street
elementary school to the C. B. Greer school.

Dr. Virginia Hamilton Maley, of Hall County, was
recently named "Woman of the Year" by the Gaines-
ville Rotary Club.

Dr. Marvin Monroe Head, of Zebulon, was hon-
ored in an editorial in the *Pike County Journal* for
his 51 years of service as a "country doctor" in
Pike County.

Dr. William H. Holden, of Macon, has returned
from an exploration trip into the heretofore unex-
plored area of Northern Brazil. The main object of
his expedition was to locate, photograph and study
the Pusiani Indians.

Dr. William Harvey Howell, of Cartersville, was
awarded a Commendation Ribbon with Metal Pen-
dant for his distinctvie and outstanding service while
serving as surgeon in the Eighth United States Army
in Korea.

Drs. T. W. Jackson and *J. A. Johnson*, both of
Manchester, were recently honored by the Man-
chester Jaycees with the presentation of plaques for
their service to the people of the community.

Dr. Lawson C. Johnson, of Manchester, was
appointed local surgeon for the Atlantic Coast Line
Railroad.

Dr. G. Lombard Kelly, of Augusta, has announced
his retirement as President of the Medical College
of Georgia. Dr. Kelly has been connected with the
Medical College of Georgia since 1918, being Dean
of the College until he was elected President—a

Dr. Arthur M. Knight, Jr., of Waycross, recently
gave an address on the topic "Geriatrics" at the
Southeastern Regional Health Conference held in
newly created office—in 1935.

Do You Have Insurance Problems?

Do you have any insurance problems? And are you satisfied with the management of the plans already in operation in the state? Attend and state your views at a Panel Discussion, Wednesday at 9:00 a.m. The subject will be "Insurance Plans and Problems in Georgia" with Mr. H. B. Coolidge, Savannah, Director of the Physicians' Association of Savannah, as moderator. Serving as Discussors are W. S. Dorough, Atlanta; W. F. Pomeroy, Waycross; John Elliott, Savannah; and J. Z. McDaniel, Albany.

Waycross.

Dr. Bernard S. Lipman, of Atlanta, has recently been certified by the American Board of Internal Medicine.

Dr. Max Mass, of Macon, addressed the Medical Staff of the Veterans Administration Hospital, Dublin, on March 19. His topic was "Experience with Operative Cholangiography."

Officers elected at the Georgia Society of Ophthalmology and Otolaryngology's Annual Convention in Savannah March 7 were: *Dr. Stacy C. Howell*, of Atlanta, president; *Dr. W. Eugene Mathews*, of Augusta, vice-president; and *Dr. Alton V. Hallum*, of Atlanta, secretary-treasurer.

Dr. Michael Arvin McCall, of Atlanta, has become engaged to Miss Joyce Kendall Palmer, of Decatur.

The wedding will take place in Decatur in the late spring.

Dr. R. P. Parnell, recently returned from duty with First Marine Division in Korea, is now associated with *Dr. J. C. Tanner* in the Oakdale Community with offices at the junction of Oakdale and the old 41 highway.

Dr. Edgar R. Pund, of Augusta, professor and director of pathology at the Medical College of Georgia since 1923, was elected president of the college by the Board of Regents of the University System of Georgia.

Dr. Julian K. Quattlebaum, of Savannah, was a speaker on the Postgraduate Lecture Series of the Veterans Administration Hospital, Dublin, on March 18. The subject of his address was "Complications Following Gastric Surgery."

Dr. Charles H. Richardson, Sr., of Macon, delivered an address on "Professional Relations" at the Georgia Pharmaceutical Association's 78th Annual Convention held in Macon April 6, 7 and 8.

Dr. Martin Smith, of Gainesville, recently addressed the Gainesville Rotary Club on the subject of the medical profession, explaining its operation and organization to fellow members of Rotary.

Dr. H. A. Thornton, formerly of Greensboro, has moved to Decatur where he will be associated with *Dr. Ed Cunningham* and *Dr. R. P. Shinall* in the practice of medicine.

City officials were invited to attend ceremonies in Savannah marking the hanging of a portrait of the late *Dr. A. J. Waring* in the Health Department Building.

HOSPITALS

In an address at the annual convention of the Georgia Hospital Association in Atlanta recently, *Dr. R. C. Williams*, director of the division of hospital services, Georgia Department of Health, reported that Georgia has 7,988 general hospital beds in use or under construction. *Dr. Williams* pointed out that this is only 52 per cent of the 15,380 beds that surveys show Georgia needs.

The Smith Sanitarium in Swainsboro was recently approved by the Georgia Department of Public Health. On the active staff are *Dr. D. D. Smith* and *Dr. H. Wilder Smith*.

Although *Drs. D. N. Johnson* and *Walton A. Johnson*, of Elberton, will continue their present practice and will maintain their offices in the building, the Thompson-Johnson Hospital will close after

serving the community for 17 years. There will be no change in the office personnel or in the laboratory.

The program for the April 16 meeting of the Northwest Region Hospital Council held at Kennestone Hospital, Marietta featured a discussion on "The Relationship Between the Medical Staff, the Administrator and the Nursing Staff." *Dr. Edward S. Marks*, of Marietta, chief of surgery at Kennestone delivered an address on this subject along with *Mrs. Ruth T. Bremer*, superintendent of Nurses at Kennestone; and *Millard L. Wear*, Kennestone administrator.

Dr. C. W. Whitworth, of Gainesville was recently honored at the Gainesville Lion's Club sight conservation program in Gainesville.

Dr. C. Roy Williams, of Wadley, has been appointed to the Courtesy Medical Staff of the Emanuel County Hospital and is now referring his private patients there for hospitalization.

AUXILIARY

Cherokee-Pickens Medical Society Auxiliary recently installed new officers for 1953-54. Those elected were: President—Mrs. G. H. Perrow, Jasper; Vice-President—Mrs. Grady N. Coker, Canton; Secretary-Treasurer—Mrs. E. A. Rogers, Jasper.

Coffee County Medical Society Auxiliary met February 25 for a luncheon meeting. Mrs. Ralph Fowler and Mrs. Leo Smith, president and president-elect of the MAG Auxiliary, respectively, met with the group. Newly elected officers are: President—Mrs. Roy Johnson; President-Elect—Mrs. Dan Jardine; Secretary—Mrs. Clavin Meeks; and Treasurer—Mrs. E. D. Bell.

DeKalb County Medical Society Auxiliary entertained the DeKalb County doctors March 9 at the Peachtree on Peachtree Hotel. Over 55 doctors and their wives enjoyed the gala event occasioned by the annual Doctor's Day observance. Mrs. William Kerr, of Chamblee, was chairman of entertainment.

Dougherty County Medical Society Auxiliary met March 2 in the Peacock Room of Davis Brothers Restaurant, Albany, and made plans for the Second District Medical Society Meeting April 2 in Albany and the March 31 observance of Doctor's Day.

Fulton County Medical Society Auxiliary heard Dr. William Hamm, of Atlanta as the opening speaker at their March 6 meeting. A movie entitled "Your Doctor" was shown and Mrs. Allen Bunce presented a paper, "And the Germs Crumble."

Georgia Medical Society Auxiliary met at the home of Mrs. R. L. Neville, March 13 to discuss plans for a costume ball to be held at the Savannah Golf Club March 28 in honor of Doctor's Day. Dr. W. R. Dancey, guest speaker on the program, spoke on the history of the Student Loan Fund.

Richmond County Medical Society Auxiliary heard Mrs. Cecil Kirven, co-chairman of the Richmond County chapter of the American Cancer Society and Mrs. J. C. Wienges, Jr., executive secretary of the Cancer Society, at their February meeting. Mrs. Stephan W. Brown, Auxiliary project chairman told

Medical Education Board

Appointed to the State Medical Education Board by Governor Herman Talmadge, were: Dr. C. F. Holton, Savannah; Dr. W. F. Reavis, Waycross; Dr. John H. Maulding, Alma; Dr. C. L. Howard, Pelham; and Dr. J. Hubert Milford, Hartwell. The duties of this Board will be to administer a state medical scholarship program, making loans to students who wish to study medicine provided they agree to practice in Georgia rural areas upon graduation.

It's Alma Mater Time

Be sure to remember that your Alumni dinner may be held Monday night, May 11, at 7:00 p.m. when grads from the Medical College of Georgia, Emory University School of Medicine, University of Virginia and Tulane University of Louisiana School of Medicine will get together.

about the work the Auxiliary is doing with the Cancer Gift-and-Loan Closet.

Stephens County Medical Society Auxiliary held a luncheon meeting February 26 at the Albermarle Hotel, Toccoa. Plans were made for the annual observance of Doctor's Day on March 31. New officers elected for the year 1953-54 are: President—Mrs. Robert E. Shiflet; President-Elect—Mrs. P. B. Cleveland; Secretary-Treasurer—Mrs. Irving Belenga; and Publicity Chairman—Mrs. S. L. Harp.

Sumter County Medical Society Auxiliary was entertained at the Americus Country Club by Mrs. Russell Thomas at a luncheon meeting. Plans were made for a Doctor's Day dinner March 26.

Ware County Medical Society Auxiliary, at their March 20 meeting, heard Mrs. Ralph Fowler, of Marietta, MAG Auxiliary President, deliver an address on the aims and objectives of the Women's Medical Auxiliary. Plans were made for the annual Doctor's Day observance on March 28. The Red Cross Fund and the Student Nurse Fund and participation in an American Legion show were subjects discussed at their business meeting.

Worth County Medical Society Auxiliary met in Ashburn at the home of Mrs. C. C. Goss for a luncheon meeting in February. Guest of honor at this meeting was Mrs. Ralph Fowler, MAG Auxiliary President, who gave a talk on the operation and organization of a local Auxiliary. Tentative plans were laid for the celebration of Doctor's Day and the members voted to make contributions to the American Medical Education Fund, the Student Loan Fund and to the Camellia Gardens at Milledgeville.

Fulton County Medical Forums

Fulton County Medical Society in conjunction with the *Atlanta Journal* has offered the public a series of eight medical forums—each on a different medical topic. Held at the Tower theater in Atlanta, the success of the public forums has been outstanding. Average attendance has been over 1200 at each of the meetings and this represents a near capacity crowd. Responsible for the success of this excellent program and planning is Dr. Chris J. McLoughlin, of Atlanta.



The cost of medical training in 1942 would produce only half a doctor today.

As a profession we are trying to meet the medical school deficits. You may earmark your check for a particular medical school.



American Medical Education Foundation

535 North Dearborn Street, Chicago 10

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Hillcrest Sanitarium	22A
Hoffman-LaRoche, Inc.	19A & 20A
Earle Johnson Sanatorium	18A
Knox Gelatine Company	33A
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Merck & Company	7A
The Nestle Company	8A
New York Polyclinic	168
Parke, Davis & Company	Second Cover & 3A
Charles Pfizer & Company	17A
Physicians Casualty Association	22A
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Catering Especially to Your Needs in
BIOLOGICALS, AMPOULES AND COUNCIL
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JOURNAL of The Medical Association of Georgia

MAY • 1953

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"VIVE LE ROI"



THEME:



Thousands of people are living good lives with bad hearts because they acted wisely and in time.

First, they did not ignore the warnings that often precede heart trouble—shortness of breath, pains in the chest, irregular beating of the heart, and constant fatigue. They heeded these warnings in knowing that their greatest security depended on taking prompt advantage of the help which medical science could give them.

Second, they accepted the limitations and restrictions imposed by a weakened heart. They

tried not to "over-do", they learned to avoid sudden exertion, and to keep weight at the normal level. They also recognized the value of sleep and relaxation, and the importance of freeing their lives from worry and strain.

Remember that in your physician's hands, you are in good hands. For today, physicians are better equipped than ever before to treat and control heart disease—and to guard against it as well. By taking advantage of the help your doctor can give you now, you increase your chances of living a good life with a bad heart.

Remember that in your physician's hands, you are in good hands. For today, physicians are better equipped than ever before to treat and control heart disease—and to guard against it as well. By taking advantage of the help your doctor can give you now, you increase your chances of living a good life with a bad heart.

Research groups from the National Heart Institute, the American Heart Association, scores of universities, hospitals, pharmaceutical companies, public and private agencies are constantly seeking new knowledge which will help physicians to control heart disease with even greater effectiveness. Parke, Davis & Company, as a maker of medicines prescribed by physicians, is proud to play its part in this great concerted effort, for it is because of such unrelenting research that there is indeed "new hope for hearts" today.

PARKE, DAVIS & CO.
Chemical and Manufacturing Corporation, Detroit 17, Michigan



This man is his own worst enemy! Yet most of us can sympathize with him—for most of us don't "run to the doctor" every time we have an ache or pain.

We're much more likely to say, "Oh, I'm all right. It's really nothing." Or to tell ourselves "I'm too busy" haven't time to bother with doctors."

Yet, the man (or woman) who ignores even minor symptoms often runs the risk of developing serious ailments. The

because most diseases thrive on neglect; the worst thing we can do is to ignore warning symptoms until it may be too late for the doctor to help.

Medical research in America today is writing one of the most heart-warming chapters in the story of mankind. Our great laboratories, our hospitals, universities, a host of governmental and private organizations are cooperating as never before to improve our chances of living a longer, healthier life.

Your own doctor has at his disposal all of the discoveries, all of the knowledge, of modern medical science. But you are the only one who can put these vast resources to work to help you.

So next time you are tempted to ignore warning symptoms, remember that the greatest danger lies in neglect and delay. Remember—in your physician's hands, you're in good hands. But only by acting promptly can you take advantage of the help he can give you now.

This message is published in the public interest by Parke, Davis & Company.
Since 1866, physicians have prescribed and pharmacists have
dispensed medicines bearing the Parke-Davis label.

PARKE, DAVIS & CO.



HIS NEGLIGENCE IS CAUSING
THOUSANDS OF DEATHS FROM
HEART DISEASE

Here's a description of the culprit:

Overweight. Short of breath. (The old ticker really pounds on a flight of stairs.)

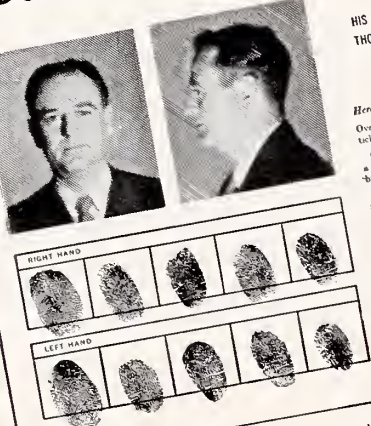
Often over-exercises on week-ends after a sedentary week. Sometimes bothered by a peculiar swelling in the ankles.

Works too hard. (Feels he's indispensable in his job.) Has trouble relaxing.

Usually sleeps poorly. Complains of being "worn-out tired."

Had a couple of attacks of "indigestion" recently. When asked by wife to please check with doctor, was heard to reply:

"What for? I'm not sick because I'm too busy!"



The greatest problem in dealing with heart disease today is the man (or woman) who ignores the "danger signals" until it is too late to take advantage of the help which medical science today is prepared to give. Yet thousands of people are living good lives with bad hearts... because they acted wisely and in time... because they knew that in their physicians' hands they were in good hands.

For it is a fact that much progress has already been made in dealing with heart ailments, and more and more research is being carried on, largely

through such great agencies as the American Heart Association and its nation-wide chapters, the National Heart Institute, and a number of pharmaceutical companies, including Parke, Davis & Company, since 1886 makers of medicines prescribed by physicians.

PARKE, DAVIS & CO.

advertisements addressed to the general public...

physician, you're in good hands"

Neglect . . . delay. How many times, doctor, have you cared for patients . . . whose hope of recovery might have been bright indeed . . . *but for neglect or delay in seeking your help?*

Undoubtedly, this occurs so often...and usually with such tragic consequences...that many physicians view it as the greatest problem facing medical science today.

Moreover, this problem may assume even greater significance with the rising incidence of the degenerative diseases. For in these conditions, neglect and delay, as you well know, are *directly* responsible for a heavy toll of life.

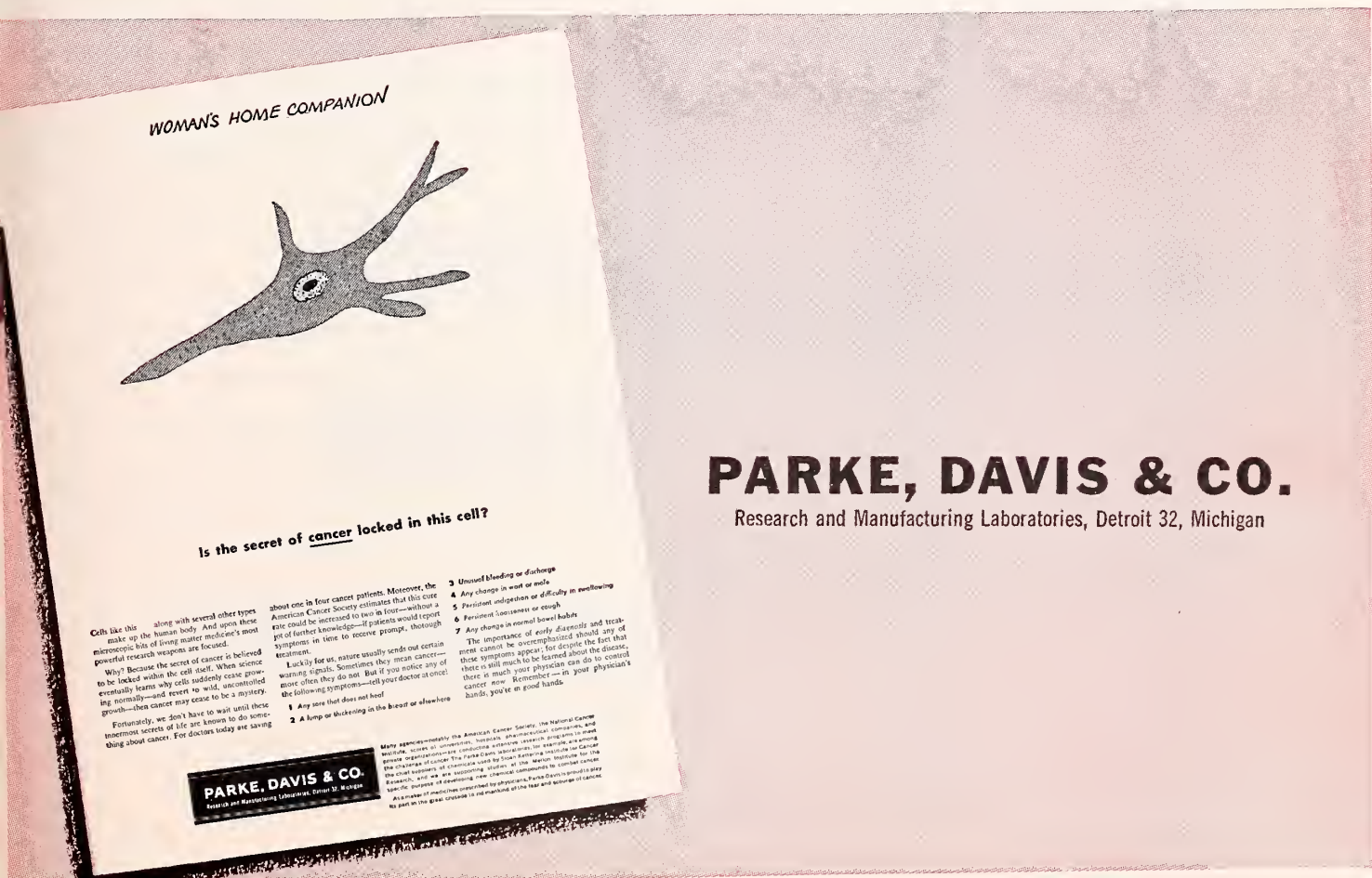
We believe you will agree that this problem deserves increased and continuing emphasis. This is why Parke-Davis will publish, throughout 1953, a series of advertisements on the *patient's responsibility* in medical care.

These advertisements, four of which are reproduced here, will appear in leading magazines reaching millions of families. In them, this central theme will be emphasized:

That every individual, if he wants his physician's most effective help, must meet the doctor halfway. He must not ignore symptoms, or delay treatment. He must act promptly . . . and be made to realize that "in the hands of your physician, you're in good hands."

In addition, the advertisements will stress the fact that medicine has a vast store of new knowledge . . . and that this knowledge is constantly increasing through research by physicians, hospitals, public and private health organizations, and pharmaceutical companies.

A word about the preparation of these advertisements: They have been carefully written to avoid both the possibility of stimulating hypochondria and encouraging self-diagnosis. Equally important, the advertisements make no claims that might cause undue optimism or raise false hopes. We believe these are just the type of informative messages you will want your patients to read. Our efforts will be guided and encouraged by your continued interest and comments.



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of the

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ASSOCIATION

OF GEORGIA

MAY, 1953

VOLUME 42 NUMBER 5

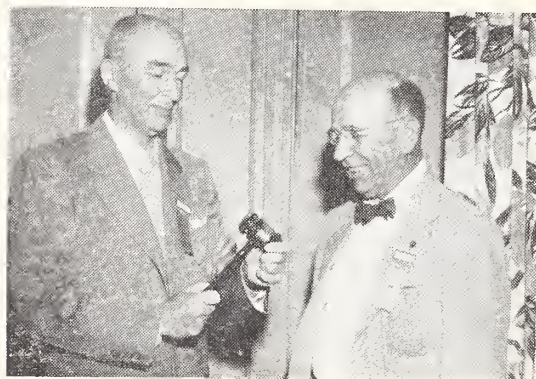


Photo by Ted F. Leigh, M.D.

Symbolic of the words of the retiring MAG President C. F. Holton, "Vive Le Roi"—a new MAG President, William Harbin, of Rome, receives the president's gavel and with it the MAG leadership for the coming year. Shown shaking hands from left to right: William Harbin and C. F. Holton. With the dust from the 103rd Annual Session hardly settled, the Association will be ably guided by President Harbin, who has had the advantage of working with Dr. Holton as president-elect for the past year.

While only a small amount of Annual Session proceedings made the deadline for the May issue of the *Journal*, the June issue will carry all the complete data of the Savannah meeting.

Many new policies for the *Journal* were discussed and approved at a meeting of the *Journal* Editorial Board May 11 in Savannah. And with these changes in policy, new members were added to the Board. As has been emphasized in the past, it is *YOUR Journal*, and the staff will continue to encourage *YOUR* suggestions and comments.

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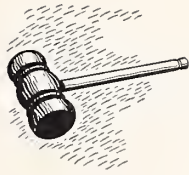
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President's Page

As our Association begins another year, it is with a deep sense of appreciation that I accept the responsibilities which you have given me. Such leadership will be carried out to the best of my ability and directed towards improvement in the welfare of the medical profession in Georgia, always remembering that we must continue to justify the confidence the public has in us.

Your officers are well aware of the part which organized medicine should and can play in shaping our professional destiny. This can be accomplished only by your active participation in the important work which lies ahead during the coming year. Although you will be called upon individually to render certain services, your committees will be responsible for the greater part of the work which is being planned. The response of committee chairmen to assignments has been very gratifying. Every effort will be made to accomplish the desired results efficiently, and with consideration of how valuable time is to those involved.

Your President feels very fortunate in having a well-organized state office to assist in and carry out our program. Without the able help of the personnel in this office, the task would be a very difficult one.

Another word of praise is in order for Cornelius Fullmer Holton and David Henry Poer. Even though their accomplishments and sacrifices are highly appreciated by the Medical Association of Georgia, they can be repaid only through the personal satisfaction of a job well done.

Sincerely,

William Harbin

The JOURNAL of the Medical Association of Georgia

When one's all right,
He's prone to spite
The Doctor's peaceful mission

But when he's sick,
It's loud and quick
He bawls for a physician.

—EUGENE FIELD

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STATEMENT OF EDITORIAL POLICY

The *Journal of The Medical Association of Georgia* established 1911. Owned, edited and Copyright, 1953 by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy.

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

GENERAL POLICY: The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Georgia.

MEDICAL EDITING SERVICE. If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.



On The Bulletin Board

Final Stages of "Doctor Draft" Legislation

Legislation now pending (S. 1531 and HR 4495, 83rd Congress) to extend the doctor draft law until July 1, 1955, differs considerably from the bill originally prepared by the Department of Defense. The AMA is primarily concerned over three important facets of these measures.

(1) The availability of a sufficient number of physicians in priorities 1, 2 and 3 to satisfy the requirements of the armed services for the next several years obviates the necessity for registry and calling into the armed forces physicians with previous military service. The AMA, therefore, has recommended that registrants or reservists falling within the definition of priority 4, be excused from any further liability under the doctor draft law.

(2) The proposed two-year extension of the law. The AMA recommends that any continuation of the law be limited to one year in the belief that compulsory legislation may no longer be necessary after July 1, 1954.

(3) It has been recommended that the special pay of \$100 per month currently payable to physicians and dentists in the armed forces be limited to those persons who volunteer for active duty in excess of 24 months. The AMA believes that this \$100 additional payment is justified and that its termination would drastically impair the medical corps' ability to attract volunteers.

The new bill reenacts the language of the present law with a few additions. In brief, the bill would:

(a) Define "active duty" and "active service" to include enlisted or commissioned service since Sept. 16, 1940, with the exception of time spent in special educational and training programs.

(b) Give credit for time spent in work of national importance by conscientious objectors during World War II.

(c) Recognize service between Sept. 16, 1940, and Sept. 2, 1945, in the armed services of any allied country.

(d) Exclude from liability for further duty physicians with 12 or more months of service since June 25, 1950. Distinction is made between service in World War II and service since June 24, 1950.

(e) Authorize the commissioning of non-citizens.

(f) Renew the authority of national, state and local medical advisory committees to the Selective Service System.

(g) Authorize the appointment or commissioning of medical officers in grades "commensurate with professional education, experience or ability."

Strauss Commission Recommends Limiting Special Pay

Congress has before it a strong recommendation

to stop the special \$100 per month pay to physicians and dentists who serve only the minimum time required under the Doctor Draw law. The recommendations come from a special five-man Defense Department-appointed commission which has been looking into military differential pay. The report also recommends elimination of extra pay for sea duty and foreign duty, and of flight pay for certain officers. The study was made at the suggestion of the Senate Armed Services Committee.

Military Physician Questionnaire

Interesting data has been obtained by the A.M.A. Council on National Emergency Medical Service from an analysis of 467 questionnaires filled out by physicians separated from active military service since June 1, 1952.

The questionnaires were analyzed to obtain information with respect to: the percentage of time spent by physicians in the treatment of military personnel and their dependents; staffing conditions, and the reasons given by physicians who have indicated that they would be willing to serve beyond the required period of 24 months.

(A) Percentage of Time Spent in Treatment of the Following Types of Patients

	MILITARY PERSONNEL		DEPENDENTS OF SERVICE PERSONNEL	
	Overseas	Domestic	Overseas	Domestic
Army	54%	53%	28%	26%
Navy	54%	46%	19%	25%
Air Force	44%	39%	19%	44%

(B) Staffing Conditions on Last Assignment

	OVERSTAFFED		UNDERSTAFFED		ADEQUATE	
	No. of Replies	Percent- age	No. of Replies	Percent- age	No. of Replies	Percent- age
Army	16	15%	30	28%	63	58%
Navy	93	34%	40	15%	138	51%
Air Force	27	44%	9	15%	26	42%

(C) Willing to Stay in Service

	Yes	No
Army	48	59
Navy	137	142
Air Force	29	35

(D) Breakdown of Reasons Given Under (C) When Answer Was "YES"

	Army	Navy	Air Force
In Case of Total War	5	6	1
If Higher Rank Available	1	1	..
Less Dependent Care	2	7	6
Better Utilization	1	7	1
Ability to Practice Specialty or Better Assignment	4	2	..
Better Rotation Policy	3	1	..
Miscellaneous Reasons	6	17	5
No Reasons Given	26	96	16
TOTAL	48	137	29

New Drugs



Coronary Vasodilating Agents

An evaluation of new drugs which augment coronary artery flow must be based on an understanding of the limitations of the methods of measuring coronary flow and an appreciation of the various factors influencing the flow.

Of the methods available for determining coronary flow, those which measure flow directly have the disadvantage of requiring artificial conditions such as open-chested animals, isolated heart or heart-lung systems and interposition of mechanical measuring devices in the blood vessels. However, such artificial conditions are, at times, desirable in that more rigid control of blood pressure and cardiac output is possible, thus reducing the number of variable factors to be considered. Methods using intact animals or man are of necessity indirect and the number of variables is greater. In this case, however, one sacrifices constant conditions for the advantage of obtaining a more comprehensive picture of events in the normal individual.

The clinical tests using relief of pain or increased exercise tolerance as criteria are of limited value. They are of no help in elucidating the mechanism of action of a drug, i.e., the observed effect may be due to increased coronary blood flow, decreased heart work, increased cardiac efficiency or a combination of these.

A drug may increase coronary artery flow by one or more of several mechanisms. It can produce dilatation of the coronary arterioles by direct relaxant effect on the smooth muscle or via the autonomic nervous system, or by passive dilatation as a result of decreased extravascular support of the vessels. Blood flow can also be augmented by an increase in systemic diastolic blood pressure and, therefore, of the perfusion pressure of the coronary system. Increased cardiac output also enhances coronary flow. From the standpoint of the treatment of coronary artery disease, agents which produce an added work load on the heart, even though coronary flow may be increased, are undesirable. Such a drug is epinephrine.

The most satisfactory drugs are those which relax the coronary arterial muscle, but which have little or no effect on the myocardium. However, no drug has such a specific effect; that is, all vascular smooth muscle is relaxed and in consequence, a fall in systemic arterial pressure may be an associated response.

Of the newer drugs, khellin (visammin) has received the most extensive study. It is a pure crystalline compound obtained from *Ammi visnaga*, a plant native to the Eastern Mediterranean area. Having

been used in Egypt for ureteral colic, it was incidentally noted that a patient receiving the drug for this condition experienced a decrease in the number of attacks of angina pectoris, to which he was subject. Studies on animals then showed that khellin causes a significant increase in coronary artery blood flow as a result of direct vasodilatation. No conspicuous fall in system blood pressure occurs in the concentrations used for coronary dilatation. No stimulant or depressant effect on the heart was noted. It was found that the magnitude and duration of action are intermediate between those of the rapidly acting nitrites and the longer acting aminophylline.¹

The reports of clinical trials have not been consistent. While earlier studies indicated definite improvement in coronary artery disease, in terms of decrease in number and severity of anginal attacks and a greater tolerance to activity, more recent reports are less enthusiastic and probably more critical. One such study² demonstrated a reduction in numbers of attacks in 50 per cent of the cases studied, but all the patients showing this improvement exhibited toxic symptoms such as anorexia, nausea, vomiting, fatigue, weakness and depression. Furthermore, the electrocardiographic abnormalities produced by exercise could not be prevented or abolished by khellin, whereas nitroglycerin uniformly and consistently did. It seems certain that khellin is of no particular advantage in the treatment of coronary artery disease.

Other drugs recently studied include such diverse compounds as adenosine triphosphate (ATP) and methyl amino heptanol, both of which dilate the coronary arteries. Neither has been shown at the present writing to be superior to agents now in use. Analogues of papaverine, such as ethaverine, are being studied, but seem to be only slightly superior to papaverine. A new xanthine, chloroethyltheophylline, has been shown to possess the coronary vasodilating effects of theophylline with less stimulation of the myocardium and central nervous system than the parent compound. It has not been studied adequately enough to establish its superiority to theophylline.

In conclusion, in spite of attempts to find new, improved coronary vasodilating drugs, the standard remedy for angina pectoris, nitroglycerin, is still the most effective drug for consistent and significant augmentation of coronary artery blood flow.

REFERENCES

1. Anrep, G. V., Kenway, M. R., and Barsoum, G. S., *Am. Heart J.*, 37:531-542, 1949.
2. Hultgren, H. N., Robertson, H. S., and Stevens, L. E., *J.A.M.A.*, 148:465-469, 1952.



The Bookshelf

BOOKS RECEIVED

PATHOGENESIS OF CANCER AND APPLIED THERAPY: By John E. Gregory, M.D., 182 pages with numerous illustrations. Bruce Humphries, Inc. Boston. Price \$7.50.

TUBERCULOSIS: By Dr. Saul Solomon, Associate Visiting Physician, Fourth Medical Division, Bellevue Hospital, New York, Associate Clinical Professor of Medicine, New York University Post-Graduate Medical School. 310 pages. Coward-McCann, Inc., New York. Price \$3.50.

GREAT MEN OF MEDICINES By Ruth Fox, illustrated by Dwight Logan. Fourth Printing. 240 pages with several illustrations. Random House, New York. Price \$2.75.

SEXUAL HARMONY IN MARRIAGE: By Oliver M. Butterfield, Ph.D., Professor of Family Life Education, Mt. San Antonio College; Formerly, Department of Child Development and Parent Education, Teachers College, Columbia University, 96 pages, 3 plates. Published March, 1953, Emerson Books, Inc. New York. Price \$1.50.

MENTAL HEALTH THROUGH WILL-TRAINING: By Abraham A. Low, M.D., Founder and Medical Director of Recovery, Inc. 393 pages. Second Edition. The Christopher Publishing House, Boston. Price \$5.00 (cloth).

BASIC PSYCHIATRY: By Edward A. Strecker, M.D., Professor of Psychiatry and Chairman of the Department of Psychiatry, School of Medicine, University of Pennsylvania, Consultant in Psychiatry to the Surgeon General of the Army; Consultant in Psychiatry to the Surgeon General of the Navy; Consultant, Philadelphia Naval Hospital; Senior Consultant in Psychiatry, Veterans Administration; Consultant in Psychiatry, U. S. Public Health Service. 473 pages. Price \$3.75.

LEONARDO DA VINCI By Sigmund Freud, authorized translation by A. A. Brill, Ph.B., M.D. A study in psychosexuality. 121 pages. Random House, New York. Price \$2.50.

PHEOCHROMOCYTOMA AND THE GENERAL PRACTITIONER: By Joseph L. DeCourcy, M.D., Cornelius B. DeCourcy, M.D., Authors of Pathology and Surgery of the Thyroid. 165 pages. DeCourcy Clinic, Cincinnati.

A MARRIAGE MANUAL: By Drs. Hannah and Abraham Stone. A practical guide-book to sex and marriage. New, Enlarged, Completely Revised Thirtieth Edition. 301 pages. Simon and Schuster, New York, 1952. Price \$3.50.

MILESTONES OF MEDICINE: By Ruth Fox. 237 pages. Random House, New York.

YOU AND YOUR HEARTS By Dr. H. M. Marvin, Associate Clinical Professor of Medicine, Yale University. A Clinic for Laymen on the Heart and Circulation. 306 pages. Random House, New York. Price \$3.00.

DISEASES OF THE ESOPHAGUS: By Dr. Philip Thorek, MD, FACS, FICS, 102 illustrations, drawings by Carl T. Linden, 140 pages. J. B. Lippincott Company, Philadelphia, London, Montreal. Price \$10.00.

MODERN TREATMENTS By Fifty-three authors, Edited by Austin Smith, M.D., Editor of the Journal of the American Medical Association and Paul L. Wermer, M.D., Secy., Committee on Research, American Medical Association. A Guide for General Practice. 1146 pages. 64 tables. Published by Paul B. Hoeber, Inc. (Medical Book Dept. of Harper & Bros., New York). Price \$20.00.

YOUR DIABETES AND HOW TO LIVE WITH IT: By Floyd L. Rogers, M.D., and Ruth M. Leverton, Ph.D., 113 pages. Revised and enlarged edition. University of Nebraska Press, Lincoln, Nebraska.

CHILDREN OF DIVORCE: By J. Louise Despert, M.D., Associate Professor of Clinical Psychiatry, Cornell University Medical College. 282 pages. Doubleday & Company, Inc., New York. Price \$3.50.

CLINICAL DIAGNOSIS BY LABORATORY METHODS: By James Campbell Todd, Ph.B., M.D., Late Professor of Clinical Pathology, University of Colorado School of Medicine; Arthur Hawley Sanford, A.M., M.D., Emeritus Professor of Clinical Pathology, The Mayo Foundation, University of Minnesota; Emeritus Member, Division of Clinical Laboratories, The Mayo Clinic; Director of Laboratories, Rochester State Hospital; and Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, Department of Medicine, School of Medicine, University of Arkansas. Twelfth Edition with 946 illustrations, 197 in color, on 403 figures. 925 pages. Published 1953 by W. B. Saunders Co., Philadelphia and London. Price \$8.50.

CLINICAL DIAGNOSIS BY LABORATORY METHODS: by James Campbell Todd, Ph.B., M.D., Arthur Hawley Sanford, A.M., M.D., and Benjamin B. Wells, M.D., Ph.D., 12th Edition. W. B. Saunders Co., Philadelphia and London. Price \$8.50.

REVIEWS

AN ATLAS OF SURGICAL EXPOSURES OF THE EXTREMITIES: By Sam W. Banks, M.D., Associate Professor of Orthopedic Surgery, Northwestern University Medical School; and Harold Laufman, M.D., Ph.D., Associate Professor of Surgery and Director of Experimental Surgery, Northwestern University Medical School. 391 pages with 552 illustrations on 179 plates. Philadelphia and London: W. B. Saunders Co., 1953. Price \$15.00.

This is the twelfth edition of a textbook that deals with the laboratory findings in Clinical Medicine.

Dr. Benjamin B. Wells, Professor of Medicine, Little Rock, Arkansas, has become one of the co-authors of the book.

This new edition of "Clinical Diagnosis by Laboratory Methods" fills the need of all physicians for an authoritative, up-to-date, book on the subject. The reviewer can offer no significant criticism.

THE MECHANISMS OF DISEASE: A STUDY OF THE AUTONOMIC NERVOUS SYSTEM, THE ENDOCRINE SYSTEM AND THE ELECTROLYTES, IN THEIR RELATIONSHIP TO CLINICAL MEDICINE. By Joseph Stambul, M.D. Price: \$15.00.

Dr. Stambul's book has the purpose, as the title implies, of describing and clarifying the processes of disease before they become fully developed. He would help us understand disease in its earliest stage, and the transition from the healthy to the diseased state.

His method is certainly unique. The emphasis is almost entirely on cells rather than tissues or organs. He feels that changes in body cells in disease are on the basis of three factors, namely, the endocrine system, the autonomic nervous system and electrolytes. Throughout the book this theme is unfolded as it relates to illness.

Dr. Stambul is himself a clinician but shows a remarkable interest and understanding of histology, physiology, and biological chemistry. He thus attempts to bridge the gap between clinical and pre-

clinical sciences and has collected a tremendous mass of facts from thousands of authors which he has sorted out and woven into the theory of the mechanism of disease. To some it might seem that the book is too technical but it is refreshing to find a new approach to disease.

He gives considerable attention to arteriosclerosis, the endocrine glands and inflammatory diseases. He gives evidence that mental illness such as schizophrenia is on an autonomic imbalance basis.

There is a large bibliography dating all the way back to 1870 and he brings in physiology from Bernard to Selye. Any clinician with a bent toward research will be interested in this book.

TREATMENT OF MENTAL DISORDER, By Leo Alexander, M.D., Published by: W. B. Saunders Company, Philadelphia and London, 1953.

This book represents the most comprehensive coverage of all forms of psychiatric treatment which the reviewer has seen in one book. The author exhibits definite understanding of the different so-called "schools" or "approaches" to understanding mental disorder, and describes with clarity many of the fundamentals of these various approaches. The author's orientation is eclectic in that he attempts to combine what he considers the good points of the psychodynamic and psycho-analytic with the various electrochemical approaches; such as, electro shock therapy. There seems to be an attempt to straddle the fence at times in difficult situations, and this may be somewhat confusing to the general medical reader. The author attempts to define the types of cases which are best treated by psychotherapy and the types which are best treated by various forms of physical treatment, such as electro-shock therapy and insulin therapy. His data is not always convincing and reflects some of the confusion which continues to exist in this very difficult field of treatment.

The author has made extensive research studies, investigating the neuro-physiologic aspects of electrical treatment, and much of his work is described in detail. This is the clearest presentation of the different forms of electrical treatment or electrotherapy which I have found. The discussion of psychotherapy gives one the feeling that the author is never willing to trust completely his competence as a psychotherapist, and in difficult cases he feels it necessary to resort to some physical form of treatment, such as electro-shock or electro-narcosis. This book cannot be considered to represent an accurate evaluation of the process of dynamic psychotherapy.

This book will prove valuable to any person trained in the field of medicine, or more especially in the field of psychiatry, who is interested in seeing a correlation of the various forms of therapy and some comparison of their results in the hands of one person who has practiced for 23 years. This cannot be considered, however, the best evaluation of those forms of psychotherapy which accomplish their results without resorting to electrical and chemical

methods of treatment.

OPHTHALMIC PATHOLOGY, an Atlas and Textbook. Published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. W. B. Saunders Company, 1952. Price \$18.00.

This book is a continuation and expansion of the well-known "Atlas of Ophthalmic Pathology" by DeCoursey and Ash, which first appeared in 1938 under the same sponsorship and enjoyed a third edition in 1942. The chief change has been the inclusion of a text based on Friedenwald's "Pathology of the Eye." Much of the content on pathogenesis has been taken from this book. The inclusion of relevant physiologic data and the arrangement of the photomicrographs to illustrate subjects corresponding to the chapter headings rather than to specific cases has materially increased the usefulness of this book.

The text is concise and up to date. The chapters dealing with glaucoma, diseases of the ocular blood vessels, and various intra-ocular inflammations are particularly well-written. The abundance of beautiful photomicrographs clearly illustrating every phase of the subject and printed on better paper than in the previous Atlases makes this book the outstanding one of its kind.

The book admirably achieves its purpose as a teaching aid to further the instruction of residents and as a source of information for the ophthalmologist pursuing the study of eye pathology. The book is highly recommended to those whose interests lie along these lines.

A MANUAL OF CLINICAL ALLERGY, By John M. Sheldon, M.D., Robert G. Lovell, M.D., Kenneth C. Matthews, M.D., University of Michigan Medical School, Department of Medicine and Allergy. Price \$8.50.

This book is just what the name implies, a very workable manual of Clinical Allergy; 397 pages written in a simple easy-to-read style. It uses the minimum amount of prose and the maximum number of charts and illustrations. It, therefore, gives a surprisingly great amount of detailed information on how to study, diagnose, and treat the allergic patient. It gives an adequate, though brief, discussion of commonly accepted principles of allergy in general, but does not go into the theories of immunology and allergy. The material is presented in a fairly arbitrary manner such as is used in teaching in medical schools and post-graduate medical training in allergy and represents well the consensus of opinion of our leading allergists. This book should be of value to any practicing physician or medical student and of particular value to internists who are interested in better recognizing and treating allergic patients. It also gives some valuable detailed information for the practitioner who is interested in establishing an allergic clinic or office.

MANUAL OF ELECTROCARDIOGRAPHY. Benjamin F. Smith. Houston, Elsevier Press, 1952. 215 pages, 119 illustrations. \$4.50.

There would seem to be very little need for additional monographs on this subject unless they make a substantial contribution to our knowledge of such a subject or simplify the grasp of such a subject better than existing works. It cannot be said that this book achieves either of these purposes.

The first three chapters discuss the technical details, anatomy, physiology and the production of an electric field by the heart beat. While this material is up to date it is not presented in sufficient detail to satisfy the serious student of electrocardiography. Eight chapters are devoted to a presentation of the clinical application of electrocardiograms. These chapters are essentially worth while. On page 33, the average duration of the QRS complex is stated to be about 0.7 second. This must be a typographical error. The colored plate on page 41, showing the electrocardiographic positions of the heart, is very good and clarifies such a presentation. In the tracing in Fig. 32 on page 55, the standard of the leads reproduced is quite short or tight and the polarity of the R wave in lead three is incorrectly stated. In Fig. 45 on page 65, the stated effect of carotid sinus pressure on the ventricular rate in auricular flutter is open to question. Instead, there seems to be a varying ventricular response as is frequently seen.

Rather brief, inadequate mention is made of Prinzmetal's theory regarding auricular flutter on page 68.

The arrhythmias are covered simply, briefly but adequately for the most part. The criteria for Right, Incomplete Bundle Branch Block are rather vague, as well as the criteria for Incomplete Left Bundle Branch Block.

On page 132, a qR complex in leads 1, AVL and V-6 is mistakenly labelled a QS complex. The discussion and illustrations of Acute Cor Pulmonale (from Sodi-Pallares) is rather brief and inadequate. In the section on myocardial infarction, the correlation of the cardiograms with the details of the different types of infarction is incomplete and the details of the types of infarction are lacking.

The chapter on Correlation of Electrocardiographic and Autopsy Findings would be improved by the inclusion of the author's interpretation of the tracings. This would help bridge a void which seems to exist in this chapter.

The wisdom of using Mecholyl as the drug of choice in auricular paroxysmal tachycardia, as advocated by the author, would be questioned by many. The chapter on "Pen Pictures of Cardiology" seems to contribute little to a monograph of this sort, although it is of interest.

While this book might be of some usefulness to beginners and other workers in the field, it is certainly not recommended for the serious student of electrocardiography nor does it contribute anything to the subject which has not been previously covered as well or better by other works on the same subject.

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Your MAG

PRESIDENT-ELECT

In introducing the distinguished new MAG President-Elect Peter Burum Wright, M.D., of Augusta, it is suffice to say that over the state of Georgia, Dr. Wright is known affectionately as "Peter."

Dr. Wright, a native of Augusta is truly Georgian. He was born in Augusta December 20, 1896 and educated in the public schools of Augusta. He later attended Porter Military Academy at Charleston and then the University of Georgia, Athens.

He received his M.D. degree at the Medical College of Georgia in 1920 and was appointed to the Medical College of Georgia faculty in 1924. He has been Professor of Orthopaedic Surgery at this institution since 1942. Dr. Wright has also been Chief of the Orthopaedic Staff at the University Hospital, Augusta, since 1942.

He is Consultant in Orthopaedic Surgery at the United States Army Hospital, Camp Gordon, Georgia; Veterans Administration Hospital, Augusta, Georgia; Georgia Railroad; and Battey State Hospital, Rome, Georgia.

Dr. Wright is a past president of the Georgia Orthopaedic Society, and an Honorary Member of the North Carolina Orthopaedic Association; the South Carolina Orthopaedic Association; and the Florida Orthopaedic Association.

He is a Fellow of the American College of Surgeons; the American Academy of Orthopaedic Surgeons; the Southeastern Surgical Congress; and the American Association for the Surgery of Trauma.

Dr. Wright is a Diplomate of the American Board of Orthopaedic Surgery and a member of the Board of Governors, American College of Surgeons. He is chairman of the Committee on Trauma, American College of Surgeons (Tennessee, Alabama, Georgia, South Carolina and Florida).

Faternally, Dr. Wright is a member of Alpha Omega Alpha Honor Medical Society, Pi Kappa Alpha Literary Fraternity and Phi Rho Sigma Medical Fraternity.

Locally in Augusta, Dr. Wright is a member of the Augusta Exchange Club, the Elks Club and the Augusta Country Club.

Through the year prior to his assuming the office of MAG President, "Peter" Wright of Augusta will become the Association's "leader of the profession."



Peter Burum Wright, M.D.

PROFESSIONAL DIGNITY

Now that hot weather is again upon us, we feel that a suggestion should be made to the profession in regard to the upholding of our professional dignity. Year by year, as summer comes, there seems to be an increasing number of physicians who make house calls and hospital rounds attired in garments much more fitted for the seashore or golf course than to the execution of their professional duties. The Medical Profession has long held a lofty and enviable position as one of the most respected and dignified of all professions. Certainly, the making of hospital rounds and house calls in slacks and sports shirts with open neck, short sleeves, and without necktie detracts greatly from the dignity not only of the physician but of the profession as a whole. Picture Sir William Osler in such raiment!

We do not feel that "clothes make the man," or that a physician must be a "man of distinction;" a

doctor's costume in no way reflects his ability. However, we do feel that pride in his profession and respect for his patients should behoove every physician to wear at least a necktie and some sort of light jacket when making professional appearances.

The heat in many of our eastern cities, and in many of our finest Medical Centers is on a par with that in Georgia during July and August. In these places, where Medicine is on its highest plane, professional calls without coat and tie are unheard of, and would not be tolerated.

Therefore, no matter the temperature, let us uphold our professional dignity, and perform professional chores in suitable attire. At other times, do as you wish!

Editor's Note: Here's a "hot" topic with which we are in complete agreement. What do you think over in Macon and Columbus?

WHAT *is the* ANSWER?

The medical profession constitutes less than two per cent of the population of the United States. And of all groups within the population enjoys, among other privileges, a prestige unsurpassed. This pinnacle which we physicians occupy has not been gained by our efforts alone. Without the assistance of the other 98 per cent of the population, our position would be a tenuous one indeed. The American people have made it possible for most of us to attain the social, economic and professional status which we have come to accept as recompense for our labors.

But oftentimes one wonders whether the insight of the physician is as it might be. One need look no farther than our own national organization mouthpiece to determine for himself the means by which most of us attained this enviable position of physician. The vast majority of American medical men are products of the public school system, the State University academic and graduate institutions and received their postgraduate training, at least in part, in public hospitals. These foregoing institutions have been established and are operated with funds derived from the taxation of all the people. Without these institutions, American medicine could not function at the level that we have today.

Since we have come to recognize that we are the privileged servants of the people, that is, as a group, the best educated privileged servants, we must also recognize that we have with this privilege assumed a responsibility asked of no other group. This responsibility does not cease once we have performed our heralded scientific feats. On the contrary, our obliga-

tions have only begun. Only half our education prepared us for medicine. The other half should have prepared us for citizenship and leadership. It is in the field of leadership that one fears we have failed. However, regardless of the section of this great country in which we live, opportunity arises for us to assume this leadership. And assume it we must. In the southern section of the country we are faced with a problem which almost 100 years ago our forebears exsanguinated themselves before the issue was resolved.

Only the melodramatic would suggest that the problem we now face is as grave or that the solution might require means similar to those of a century ago. Certainly our advantages of education and the experiences of the veteran necessitate that the solution require not violence, but peace; not emotions but intelligence; not prejudice but tolerance; not narrow-minded but liberal interpretation. The Negro physician of the South is in his own way crying for help. Sometimes his cry reaches the ear garbled and confused by the voices of his well meaning brothers from the North. But a cry it is. And its meaning we of the South recognize. The Negro physician desires recognition by his white colleagues. He has come to us first with his plight and should we fail to accept this challenge and refuse to help, we have only ourselves to blame if and when he seeks the help of his own people elsewhere.

We in the South have a great heritage. We are known for and take pride in our hospitality, our standard of morals and our traditional patriotism. We are called upon at this time to exercise all of

these virtues to amicably and satisfactorily solve the problem of admission of Negro physicians to our White County Medical Societies. How we shall solve this problem, no one knows but all the country has

its eyes focused upon us at this time. And as we have said so often in the past we shall again behave like gentlemen and solve this issue with the same courage, valor and dignity which we have exhibited in the past.

—PETER L. SCARDINO, M.D.

MEMORIUM

The Thomas County Medical Society asked Dr. Charles Wall, Thomasville, to write a memoriam to the late Dr. T. Allen Futch. It is fitting that this memoriam be printed in the official publication of the Medical Association of Georgia.

Dr. Futch was 44 years old, born and reared in Thomasville and educated at the University of Georgia and the Medical College of Georgia at Augusta. He served an internship in the Thomasville Hospital and was a brilliant young practitioner. He entered the Armed Forces in the late war by the force of his own initiative being rejected three separate times before he finally contrived to be accepted. He served in the Eastern Theatre of activities in Burma, India and parts of China along the Lido Road. He also had a good deal of combat experience with guerrillas in that section.

While in this theatre of operation Dr. Futch contracted a malignant form of malaria and was quite

ill during his latter months of service. On being dismissed from the Army, he came back to Thomasville and valiantly went into practice again despite his physical condition. He was a member of the Archbold Memorial Hospital staff.

During his practice, Dr. Futch had a serious eye condition caused by filaria which was extremely painful and caused him untold suffering. Finally overcoming this, he developed a bone tumor on one of his leg bones, and this again caused him a great deal of anguish and apprehension. During the excruciating sieges of illness, he carried on in the finest tradition of the practice of the healing arts. In the recent months of his life, he had been in a definite state of depression which ended with his untimely death March 20.

The Thomas County Medical Society and the staff of the Archbold Memorial Hospital feel the deepest sympathy and sincere regret at this loss to medicine.

CHARLEY WALL, M.D.

S.A.M.A. at EMORY

The Emory University chapter of the Student American Medical Association was officially organized in November 1952. A constitution, drawn up by a constitution-planning committee previously, was unanimously approved. The following officers were elected for the year 1952-53:

President—Harvey Merlin

Vice-President—Pete Sotus

Secretary-Treasurer—Barbara Stephenson

Dr. Tully T. Blalock, secretary of the Fulton County Medical Society at the time, was the guest speaker for the evening. He gave an interesting talk on various aspects of the society of interest to the students as future doctors and members of similar organizations.

Advisors elected or appointed to the chapter are:

Dr. R. Hugh Wood, Dean of Emory Medical School

Dr. H. W. Ades, Faculty Advisor

Dr. R. H. Smoot, Faculty Advisor

Dr. E. A. Allen, Advisor from Fulton Medical Society

Dr. D. H. Poer, Advisor from the M.A.G.

The National Convention of the S.A.M.A., held in Chicago, Dec. 28-30, was attended by Harvey Merlin as official delegate from Emory. Mr. Merlin

had an interesting time and learned much of value to the organization. He was appointed chairman of the 4th district regional committee on internships. Other schools in the district are Georgia and Alabama. Under this system each school is responsible for investigating the success of the intern-match plan.

A regular meeting was held February 5, 1953. Following the business meeting a film was shown. It was "Endoscopic Cinematography of the Ear, Nose, and Throat", on loan from the Motion Picture Library of the A.M.A.

The officers of the organization were privileged to attend a meeting of the Executive Council of the M.A.G. on January 11, 1953. They also were present at the meeting of the Fulton County Medical Society on January 15 and were guests of Dr. E. A. Allen at the dinner preceding the meeting. The officers found these meetings to be most interesting and informative.

At the final chapter meeting of the year on May 4, new officers and advisors will be elected, as well as the delegate to the National Convention to be held in Chicago in June this year and hereafter. A film, title to be announced later, will be shown following the business meeting.

Treatment of

TUBERCULOSIS MENINGITIS

RUFUS F. PAYNE, M.D., Rome

Prior to the use of streptomycin, mortality from tuberculous meningitis was certainly well above 99 per cent with recoveries either being classified as the serious type¹ or as having been mistakes in diagnosis. In 1946² Hinshaw and his group described four apparent "cures" following treatment with streptomycin and there have been numerous reports since that time of both "apparent" and "permanent" cures with the percentage of satisfactory results varying greatly.

Although streptomycin has been the common denominator in all of the successfully treated cases there have been considerable differences in reported results, and particularly long term results. Lincoln³ reports unusually good results in children by the use of promizole in combination with streptomycin, although this has not been confirmed by the more recent reports of the Veterans Administration.⁴ Cairns⁵ reports excellent results from streptomycin, especially when combined with neurosurgical techniques, allowing for daily intrathecal injections of the drug, though the spinal subarachnoid space became blocked. Injections, intrathecally, of tuberculin was reported in the same paper with apparently astounding results in a few cases. The addition of para-amino-salicylic acid, either by intravenous or by oral route, has apparently been added to all streptomycin regimes during the past year or two since it significantly delays the emergence of streptomycin resistant organisms, as measured by laboratory determinations on organisms collected from sputum. The data reported by the Eleventh VA-Army-Navy Conference⁴ at St. Louis in January, 1952 indicates that there is a significant difference in the mortality rate of patients treated on this regimen as compared to those persons treated either on streptomycin alone or with streptomycin in combination with promizole.

Discrepancies in the reported mortality rates in different series must have some logical explanation other than the variations in the amount of drug, the mode of administration and the length of time given, since the principles of therapy are remarkably similar in the different series. It is generally agreed that there are significant differences in mortality when

meningitis is associated with or follows acute generalized hematogenous tuberculosis, and there may be a difference in mortality in children as compared with adults as has been suggested by Bunn.⁶ There is not likely to be any serious differences of opinion that age and race play an important part in the recovery rate, especially when the two extremes of age are considered, and the likelihood of recovery would certainly be expected to be influenced by the severity of other lesions than those of the meninges. It should be axiomatic that early diagnosis and treatment is essential for the best results of therapy and the primary purpose of this paper is to report the results which we have had at Battey State Hospital which add emphasis to this view.

Lincoln⁷ has stressed the importance of making an early diagnosis in tuberculous meningitis and cites several examples to show that extensive damage may have already occurred before the classical symptoms of nuchal rigidity, vomiting, drowsiness, convulsions and involvement of the cranial nerves has taken place. The concept of Rich and McCordock⁸ that tuberculous meningitis develops frequently from small caseous cortical tubercles or caseous meningeal plaques makes it imperative that we have a high index of suspicion toward tuberculosis as being the responsible factor when headache, fever of unexplained origin, and ill defined neurological symptoms present themselves in persons, either children or adults, known to have an active or recently active tuberculosis.

We have been content to make a clinical diagnosis of tuberculous meningitis and await bacteriological confirmation by means of culture or animal inoculation as we have not been able to demonstrate acid fast organisms in nearly so high a percentage of cases as Cairns⁵ reported in his series. In all of the cases reported we have been able to demonstrate organisms and/or the following clinical characteristic picture of tuberculous meningitis: headache; stiff (but not necessarily rigid) neck; sudden and unexplained rise in fever; positive Kernig; a clear spinal fluid, under increased pressure; cell counts ranging from 10 to 400 in early cases with a

Read before Section on Thoracic Diseases at the One Hundred Second Annual Session of the Medical Association of Georgia, May 14, 1952.

predominance of lymphocytes; sugar below 50 mgm. per cent and showing a fall on subsequent taps; chlorides less than 700 mgm. per cent. Only two patients have been treated for meningitis (both are excluded from this series) who failed to meet these criteria. One was a patient who was reported to have a spinal fluid sugar of 30 before admission and treatment was continued until we could demonstrate a diagnostic titre for lymphocytic choriomeningitis. The other patient probably had a serous tuberculous meningitis since her chlorides and sugars failed to fall, but her cell count continued elevated for several weeks and treatment was continued for the regular period.

Treatment schedules have not varied markedly for the series. The earlier cases received streptomycin alone while the cases since 1949 have received both streptomycin and para-amino-salicylic acid. The earlier cases were given larger doses intrathecally, 250 mgm., but this dosage was dropped to 100 mgm. late in 1947. In general the treatment schedules at the present time are as follows: 1 gram streptomycin and 10 grams of PAS is given daily by the usual routes of administration and is continued for at least six months. If there is no evidence of relapse, the streptomycin is given twice weekly and PAS daily for an additional six months. Streptomycin is given intrathecally in 100 mgm. doses on alternate days for two to four weeks, and if improvement continues, is reduced to twice weekly for an additional two to four months and then weekly until at least six months intrathecal treatment is given. If evidence of irritation such as high cell count, yellow fluid, extremely high protein or cord block develops, the dosages or intervals of treatment may be reduced. These dosages are usually well tolerated however and the need for modification does not often arise. Intravenous PAS has been given in those cases where the drug could not be tolerated by mouth.

From January of 1947 through December of 1951 we have made a diagnosis of tuberculous meningitis on 37 patients. In addition there are two cases who are alive and doing well that were diagnosed late in 1951, but since they have not survived six months of therapy they are not included in the tabulations, although we have included one death in which diagnosis was made during the last three months of 1951.

Analysis of Cases as Related to Mortality

Cases treated	37
Cases alive (over 6 months).....	15
Cases dead	22

While the overall survival rate is not as high as reported by Cairns, it is higher than the rate reported by the Veterans Administration. It is suspected that both the Veterans Administration Hospitals and Battey have had a larger proportion of patients admitted in the more advanced stages than was true in either the Oxford series reported by Cairns or in the Bellevue series reported by Lincoln and Kirmse.

Analysis by Age and Color

Age Group	Alive		Dead	
	White	Colored	White	Colored
Under 10	0	0	2	1
10 ----- 19	2	0	0	0
20 ----- 29	4	1	3	2
30 ----- 39	1	1	3	1
40 ----- 49	5	0	3	1
50 ----- 59	1	0	2	0
60 ----- 69	0	0	2	1
70 and over	0	0	1	0
Total	13	2	16	6

While the series is not large enough to have statistical significance, it is quite suggestive that the overall mortality in the colored is much higher than among the whites. Both colored patients who survived were in the hospital when symptoms developed and were placed on treatment immediately.

Patients giving history of having taken streptomycin for at least one month or longer before onset of symptoms:

	Yes	No
Alive	4	11
Dead	9	13

It is reasonable to assume that patients who have been on streptomycin therapy previously would have a much less chance of survival than would patients who were virgin to chemotherapy. Of the 11 patients who developed meningitis after streptomycin therapy it was noted that seven were miliary cases and of this number only one survived.

Antecedent Tuberculous History

	Alive	Dead
Miliary Tuberculosis	5	13
Pleural Effusion	4	2
Pulmonary Disease	3	7
Generalized Spread*	3	0

*A recent spread involving more than one organ but no evidence of pulmonary miliary involvement.

Tuberculous meningitis developed in less than three months after the onset of the antecedent lesion except for those patients who had only a pulmonary lesion and one patient who did not develop meningitis until nine months after the onset of miliary tuberculosis and one other miliary case who had been treated for one hundred twenty days before onset of meningitis.

Time from Onset of First Symptoms to Start of Treatment:

	Alive	Dead
Under 1 week (in sanatorium).....	11	11
Under 1 week (at home).....	2	0
Under 1 week total.....	13	11
1 ----- 4 weeks*.....	1	3
Over 4 weeks*.....	1	8

*These patients were all admitted to hospital after onset of symptoms and before any specific treatment was given.

Again, our series of cases is too small to attach statistical significance to the above table, but it is certainly suggestive when it is noted that more than half of the patients survived in whom treatment was

started less than one week after the onset of symptoms. It would have greater significance if we could withdraw those cases who were admitted in a semi-coma and could give no history of their onset date forcing us to accept the history from a relative who may not have been very observant.

***Cytology and Bacteriological Findings on First Specimen of Spinal Fluid as Related to Mortality:**

Cell Count		Alive		Dead	
		Pos. Bact.	Neg. Bact.	Pos. Bact.	Neg. Bact.
10	99	2	4	5	4
100	199	1	2	1	3
200	299	0	0	1	1
300	399	2	1	1	1
400	plus	2	1	1	3
		7	8	9	12

***Spinal Fluid Sugar on First Specimen of Spinal Fluid as Related to Mortality:**

Sugar Mg. %		Alive		Dead	
		Pos. Bact.	Neg. Bact.	Pos. Bact.	Neg. Bact.
Under 30		3	5	3	2
30 39		2	1	4	2
40 49		1	1	2	3
50 55		1	1	1	3
		7	8	10	10

***Spinal Fluid Chlorides on First Specimen of Spinal Fluid as Related to Mortality:**

Chlorides Mg. %		Alive		Dead	
		Pos. Bact.	Neg. Bact.	Pos. Bact.	Neg. Bact.
400 499		0	1	1	2
500 599		3	1	3	1
600 699		1	2	5	4
700 & over		0	2	0	0
		4	7	9	7

*The first specimen to be examined was not always completely studied due to the usual factors affecting laboratory services and for this reason the totals vary.

At first glance it would appear that bacteriological proof is lacking in many cases but we again call to your attention the fact that these results refer only to the first specimen, and that there was no apparent differences between the results in those who died as compared with those who lived. There is no doubt also that our bacteriological procedures are more sensitive now than they were in 1947 and 1948 as is evidenced by the fact that positive bacteriology has been obtained on the first specimen in five of the last seven patients who are still alive.

The development of spinal block is apparently seen much more frequently in children than in adults since this complication was noted only in five instances in the 34 adults but was apparent in two of the three children under 10. Intrathecal tuberculin was tried in only one case but was of no apparent value. Fortunately we have had no others who appeared to need it since the only other patient who has developed block since this treatment was described⁵ has responded to continued spinal injections of streptomycin and now has free dynamics.

Of the five adults who developed symptoms of block, three are still alive but one has considerable cord damage which was present at the time of admis-

sion to Battey. Another is apparently completely free of residual damage while the other is slowly but definitely showing a return to normal after several week of vegetation. Our experience to date is small but we are under the impression that too frequent or too large doses of intrathecal medication plays a definite role in the development of this condition, although we do admit that it is most likely to occur when diagnosis has been delayed longer than one week.

Protein determinations appear to have some prognostic significance since the original specimen of eight patients who survived showed less than 100 milligrams while only one of 13 patients who died showed less than 100 milligrams. Here again however, the amount of protein present was more definitely correlated with the length of time that the disease had been present.

Time of Death in Relation to Start of Treatment:

Under three months	15 or 70%
Under six months	20 or 90%
Under one year	22 or 100%

Survival Time for Patients Who Are Still Alive:

6	12 months	3
13	24 months	4
25	36 months	2
37	60 months	6

From our experience we have become very optimistic over the chance for ultimate survival in patients who have not relapsed by the end of six months of treatment. More than one-fourth of all our deaths in this series occurred before the end of one week of treatment and for the most part represent those cases admitted to the hospital in a moribund state.

Residual Damage Following Treatment:

Severe Deafness	6
Cord Lesion	1
Severe Brain Damage	1

In discussing tuberculous meningitis Rich⁸ states that "the symptoms of tuberculous meningitis appear to be due principally to five effects upon the central nervous system: (1) mechanical irritation, (2) hypersensitivity, (3) vascular obstruction, (4) extension of infection to the nervous system, (5) increased intracranial pressure." While the deafness appears to be primarily the result of ototoxicity of streptomycin, the other residual lesions can be accounted for on the basis of the above effects of the disease, and the more advanced the lesion when treatment begins, the more likely is the patient to have residual lesions if he is fortunate enough to recover. The cord lesion referred to above had already developed when the patient was admitted to the hospital, although one other patient completely recovered after having muscle weakness of the lower extremities.

Conclusions

Thirty-seven consecutive cases of tuberculous meningitis admitted to Battey State Hospital during the four year period 1947 to 1951 and treated with combined intrathecal and intramuscular streptomycin have been presented with the results of treatment.

Evidence has been presented that early diagnosis can be made on the basis of clinical symptoms and signs when correlated with the spinal fluid findings in patients known to have active or recent active tuberculous foci elsewhere in the body.

Experience indicates that recoveries with minimal residual nerve damage can be expected in approximately one-half of the cases if diagnosis is established early and if the patient is energetically treated.

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DISCUSSION

DR. MARTIN M. CUMMINGS (Atlanta): I wish to congratulate Dr. Payne on his very fine analysis of the experience of the Battey Hospital staff in the management and treatment of tuberculous meningitis. His observations parallel very closely those which we have observed in the Veterans Administration. In general the best results were

obtained in the treatment of miliary tuberculosis with streptomycin and PAS; poorer results have been observed in the treatment of tuberculous meningitis; and the worse results have been seen in those patients who have had both miliary tuberculosis and meningitis.

A recent analysis of the combined experience of the Veterans Administration, the Army and Navy, revealed, after a three-year follow-up, the following data:

	Number cases	Survival
Miliary only	121	45%
Meningitis only	181	24%
Miliary plus meningitis	65	10%

Our interest recently has been concerned with the management of the patient with tuberculous meningitis who developed spinal-cord block. Whether this block is a result of the disease process itself, or perhaps of the intrathecal administration of streptomycin cannot be stated with absolute certainty. However once a block has occurred results of treatment have been uniformly poor and fatality was almost certain.

We have been intrigued by the reports of the Oxford group in England suggesting that the combined use of intrathecal tuberculin and streptomycin may often salvage such individuals. This treatment, which employs neurosurgical assistance in establishing open drainage through the ventricles, has been recently tried in our hospital with most dramatic success. Unfortunately time limits the discussion of the specific recent experience with the tuberculin treatment of this complication. It is my belief that we should be more vigorous in the management of patients with tuberculous meningitis who develop spinal block than we have heretofore.

The treatment of any disease which is uniformly fatal is most challenging. In this regard one can say that streptomycin and other chemotherapeutic agents such as PAS have definitely altered the natural history of tuberculous meningitis. However there still is a great need for further advances along these lines and we wait with great interest for the accumulation of the experiences of treatment of this infection with the newer chemotherapeutic agents such as the isonicotinic acid derivatives.

Library Photostat Service

The A. W. Calhoun Medical Library, Emory University, Georgia, has a new service to offer. They now have a photostating machine and are experimenting with photostats to be used in place of out-of-town loans and for copies of pages from material which does not circulate—such as current periodicals.

They think that the use of photostats will ameliorate, if not completely cure, the conflict between the circulation and reference functions of the library. They hope that you will find this additional facility helpful. One of the advantages, particularly to the out-of-town doctor, is that the borrower will not have the inconvenience of wrapping and mailing the material for return to the library. As the photostat will belong to the borrower he will not have to read the material in a hurry in order to meet the deadline of the library's loan period.

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The Role of CYTOLOGY in PROSTATIC CANCER

Cancer of the prostate is an insidious disease. Early diagnosis is not easy, and treatment is far from satisfactory; yet it is one of the commonest forms of malignant disease in man.^{1 2} Certainly, any improved diagnostic method is needed. In 1932, Mulholland³ advocated the smear method, which was popularized later by Papanicolaou.⁴

At the State Hospital in Milledgeville, we ran a screening process on 1,259 men aged 45 years and over. Among this group without symptoms there were 20 in whom prostatic disease was diagnosed clinically as malignant. In 14 of this number the results of examination were positive from a cytologic standpoint; in the other six there was so much induration that we could not produce secretion by massage, except a small amount in one, which gave a negative reaction. In 42 patients, smears were suggestive of malignant disease, and in 72, cells were suspicious enough to warrant continued observation with repeat smears.

Ten patients were extremely poor surgical risks, with grade III to IV enlargement from hyperplasia. They were treated with large doses of stilbestrol.* 300 to 900 mg. daily for 14 days, together with drainage by catheter (fig. 1). In five patients, glands

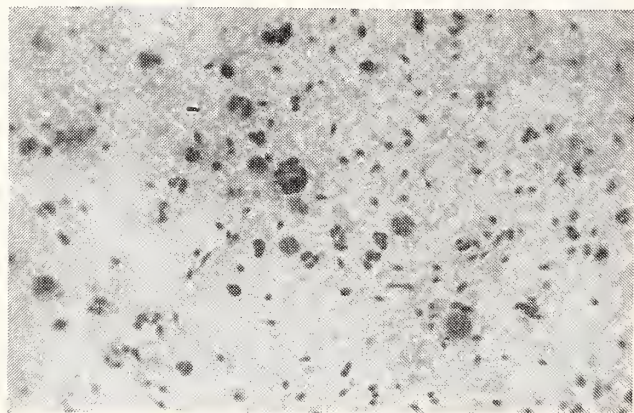


Figure 1. Normal prostatic secretions.

Read before the Section on Urology at the One Hundred Second Annual Session of the Medical Association of Georgia, May 12, 1952.

*The stilbestrol was furnished by Eli Lilly & Company.

We wish to express our appreciation to the United States Public Health Service; Dr. Peacock; Dr. Mullins, pathologist; Dr. Pund, pathologist of the University Hospital of Augusta; and Dr. Nieburgs' staff for their untiring efforts in helping us to carry out this project and also to Dr. Harold P. McDonald, Chief Consultant in Urology at the State Hospital and the members of the State Hospital Staff.

measuring seven to eight cm. in length shrank in two weeks to four to five cm., the reduction making resection much easier. Side effects were controlled with antihistamines, and five patients were given 25 mg. of testosterone weekly to help doubtful cardiac status.

Twenty-five patients with benign hyperplasia received five mg. of stilbestrol daily for six weeks without appreciable shrinkage. Smears were examined and biopsies performed before, during and after the treatment. We observed the same cellular changes which were mentioned by Peters,⁵ Herbut and Lubin,⁶ Huggins⁷ and others, increased squamous cells.

Two patients with malignant disease of the prostate were treated with progesterone. We followed the course of the disease by means of smears and biopsies. In one patient skeletal metastasis, cerebral metastasis and metastasis to the left testicle were present. He responded enough clinically to recover in a period of six weeks from coma and psychosis due to cerebral metastasis. He then was subjected to orchiectomy and was given large doses of stilbestrol. Thereafter, he survived six months.

The other patient was given progesterone for six months and showed great improvement. The smears and biopsy even gave negative results, but at the end of one year with this therapy, the malignant process had increased in size and induration. Also, the ketosteroids and the acid phosphatase had increased.

Under testosterone therapy we noticed increased numbers of columnar epithelial cells with increased basophilic staining and fewer squamous cells. We are repeating the study of 25 patients with prostatic hyperplasia.

From an anatomic point of view, we believe that exfoliative cytology is of value because the prostate lies in the male pelvis at the base of the bladder and is palpable by rectum generally about one and one-half inches above the sphincter on the anterior rectal wall. It is compound musculotubuloacinous gland, and it arises embryologically from five sets of tubules that later drain the acini into the prostatic urethra.⁸ These tubules collect into ducts, the lateral having 10 to 15 ducts each, the anterior one to three, the posterior six to 10 and the median six to 12. By a massaging process over the prostate one should be able to collect representative specimens from the acini and the ducts, unless they are obstructed. On palpation, carcinoma is suspected when one notes nodules or an area in the prostate of increased consistency that is distinctly firmer and fairly sharply localized, with

firm, distinct edges. These lesions may also be produced by chronic inflammatory changes, infarcts and calculi. They may become further advanced and produce a mass of inelastic tissue between the lateral lobes, eliminating the natural furrow. Some are of rapid growth, and others grow so slowly that it is doubtful that they are an impediment to the patient's health. In questionable cases, one may palpate over sounds or inject the area with procaine, then employ massage; also, one may resort to needle biopsy at the same time.

We use the transurethral method of obtaining specimens for biopsy in those cases in which it is indicated. We do not employ the open perineal method. For needle biopsy we use the Roth-Turkel serrated trephine needle (fig. 2). We employ the usual technic for infiltration of the perineum and the periphstatic tissue, by rectal palpation guiding the point of the needle into the lesion suspected.

Technic of Collecting Material for Smears

1. Have the patient void one-half of the urine.
2. Have the patient, with the lower part of the body disrobed, mount a table and assume the knee-elbow position on the table.
3. Insert the well lubricated index finger of the gloved examining hand into the rectum.
4. Outline the prostate as to size, shape and consistency and note the seminal vesicles; also determine the mobility of the gland.
5. Begin a firm massage, first of the lateral lobes, then the median and posterior lobes with a stripping process.
6. Collect the material by expressing a drop on a clean dry slide.
7. Place another slide face down on this slide near the end with the drop on it and draw apart to make a thin film or smear of one cell thickness on the two slides. This procedure may be repeated as often as one thinks necessary to get a representative smear, preferably three sets of slides. Allow these slides to stand in the open air for one minute, then immerse the two slides faced together in a solution of 50 per cent ether and 50 per cent ethyl alcohol. This preparation should be fixed for 30 minutes. Place a drop of glycerin between the two slides and forward to the cytologist.

The problems of palpation and massage are that some patients are hypersensitive, especially the demented, and that the carcinomatous prostate may be so indurated in the advanced cases

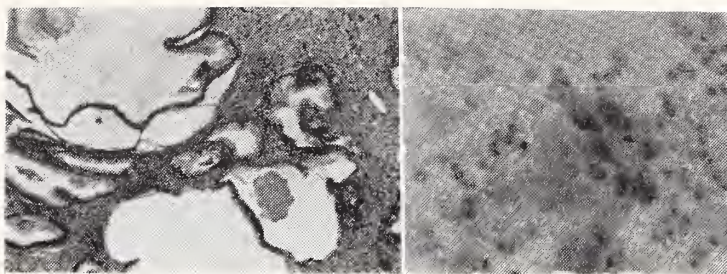


Figure 2. Benign prostatic hyperplasia smear and biopsy.

that it is impossible to collect one drop of secretion. The massaging process may then be followed by having the patient void the remainder of the urine into a bottle containing five cc. of five per cent formalin, from the sediment of which smears should be made.

Cytologic changes noted in normal and abnormal smears include squamous epithelial cells which appear in groups or singly and are similar to those in vaginal smears, that is, large polyhedral cells with abundant cytoplasm and small nuclei, with the younger cells having larger nuclei.^{5 6 9} Under estrogen therapy these cells show an orange color. These squamous cells arise mostly from the urethra and the prostatic ducts.

The columnar epithelial cells appear rounded, singly or in groups. They are about twice the size of the leukocytes with the nuclei occupying one-half of the cell volume. Cell membranes are well defined and thin with nuclear chromatin dispersed in fine granules. There is an increase in the number and size of cells. The cells from the seminal vesicles sometimes contain large pigment granules.

Histiocytes may resemble columnar cells and are usually found in groups massed together. As a rule, they contain foreign bodies, such as blood elements. Corpora smylacea are seen as masses of homogeneous pink or orange material, with no organized internal structure. Spermatozoa, bacteria and blood elements are the same here as elsewhere. Lecithin granules form the granular background (fig. 3).

Malignant Characteristics

The cells tend to be larger than normal columnar epithelial cells; that is, they are three to five times the size of a leukocyte, the normal being two to one. The nuclei show a greater relative increase in size than the cytoplasm, and the cytoplasm may be hardly discernible. The nuclear chromatin is coarse and has a tendency toward clumping. The cells are crowded

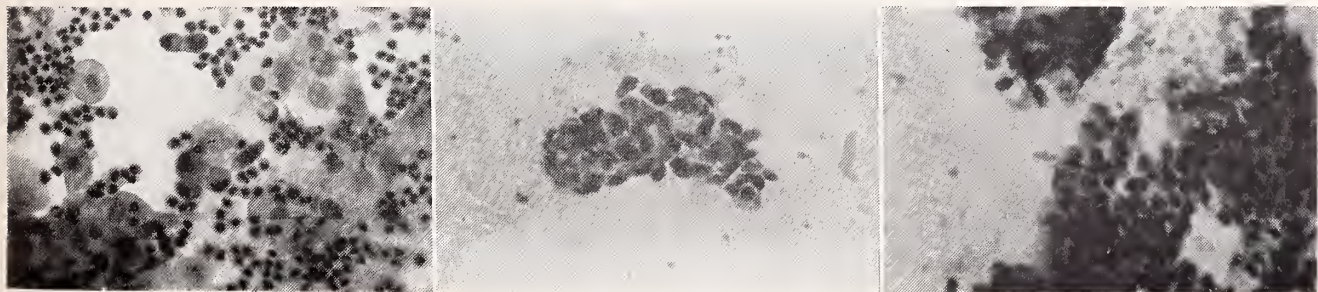


Figure 3. Carcinoma prostatic secretions.

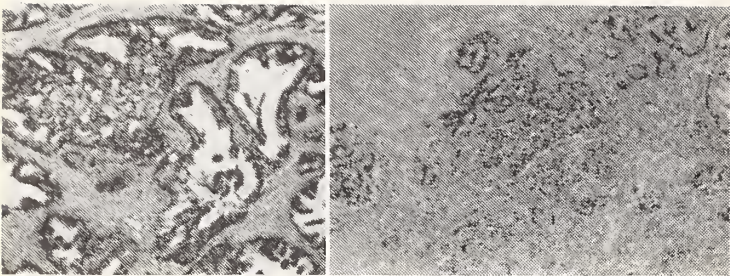


Figure 4. Biopsy of prostatic carcinoma.

into clusters and show a loss of cellular uniformity and individuality (fig. 4).

Summary

We agree with other investigators in believing that one definitely can obtain malignant cells from secretions of the prostate, but to do so requires careful, adequate massaging technic, adequate specimens and care in interpretation.

Negative evidence from smears is not to be accepted as final because one must remember that to be of value material for smears must be collected from the involved areas and the ductules draining the area must not be obstructed.

Interpretation requires much experience because on pathologic sections prostatic carcinoma is most difficult to diagnose and many pathologists will disagree upon one pathologic section. It seems, therefore, that it would be only natural for there to be some difficulty in differentiation on cellular determination alone.

This procedure is another step in the process of diagnosis and is not to supplant other procedures, but it can be used to complement them. A smear giving negative evidence is by no means conclusive, but a smear giving positive evidence is an indication for radical surgery to some investigators, notably Albers, McDonald and Thompson of the Mayo Clinic.

We are now conducting a study of a small series of cases in which a test will be made of certain pertinent medication, which should increase the amount of exfoliative columnar epithelial cells.

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Internship Program

On July 1 more than 6,000 new doctors from U. S. medical schools will begin internships at hospitals throughout the country. As a result of a national matching plan, now in its second year of operation, ninety-five per cent of the interns will complete their formal medical training at the hospital of their first or second choice, according to a report on the recently completed program in the April issue of *The Journal of Medical Education*. Eighty-five per cent of the students received their first choice internship.

The national matching plan was set up last year to lessen difficulties caused primarily by the disparity between the number of internships and doctors available to fill them. The difference between the number of internships and available new doctors continued this year at about the same rate. While 6,033 students participated in the plan, some 10,971 internships were offered.

The matching plan has gained increasing support from students and hospitals since its inception last year. It was proposed in 1950, but the first participants were 1952 graduates. The plan has been found impartial and orderly, helping to relieve pressures on both students and hospitals.

The plan places no restrictions on the student as to the number of internships for which he may

apply, or on hospitals for the number of internships they may offer. Both students and hospitals are free to negotiate with each other in the normal competitive American fashion, short of actually signing a contract.

Students apply directly to the hospitals, then send to the matching program headquarters in Chicago a list of the internships for which they applied, in order of preference. Hospitals do the same with applications they receive. To provide speed and accuracy, information obtained is transferred to punched cards and the actual matching is done by punched-card machines. Students are matched only to a hospital for which they have applied, and hospitals are matched only with students they have indicated they wish to accept.

Operating under a new name, the National Intern Matching Program, Inc., the corporation is owned and controlled by the Association of American Medical Colleges, Council on Medical Education and Hospitals of the American Medical Association, American Hospital Association, American Protestant Hospital Association and the Catholic Hospital Association. The directors include student representatives. Various government services are also represented.

POLYRADICULONEURITIS

(Landry-Guillain-Barre Syndrome)

Associated with INFECTIOUS MONONUCLEOSIS:

Infectious mononucleosis has been generally regarded as a benign infectious disease, probably of viral etiology, characterized by fever, sore throat, lymphadenopathy and a characteristic hematological picture. However, over the past few years increasing reports of serious complications have led to the concept that infectious mononucleosis is a systemic disease with a variety of clinical manifestations dependent upon the organ or system primarily involved by the pathologic process.

In 1931 Epstein and Dameshek¹ and Johansen² first reported involvement of the nervous system, lymphocytic meningitis, in infectious mononucleosis. Since that time numerous reports of cases showing predominant neurological manifestations have been published. In 1950 Silversides and Richardson³ collected 59 cases of neurological complications from the literature and added four cases of their own. They classify neurological manifestations of infectious mononucleosis into four main groups, (a) Lymphocytic or serous meningitis, (b) Encephalitis and related forms, (c) Polyneuritis of the Guillain-Barre type, and (d) Neuritis. Of these, the first two are the most common. As a rule recovery from neurological complications is rapid, however, permanent residua and even death, usually as a result of respiratory paralysis, may occur.⁴

The syndrome of polyneuritis, with flaccid paralysis and sensory disturbances, and albuminocytologic dissociation of the spinal fluid has been designated by many names, viz., infectious polyneuritis, infectious neuronitis, Guillain-Barre syndrome, etc. Haymaker and Kernohan⁵ from their clinicopathologic study of 50 such cases, including cases of Landry's ascending paralysis, concluded that all of these disorders fall into a single category. Finding patho-anatomic terms rather inadequate, they suggested the eponymic designation, Landry-Guillain-Barre syndrome. Hiller and Fox⁶ in 1943 first described

Report of a Case

this syndrome in a case of infectious mononucleosis. In 1947 Ricker et al⁷ reported clinical and pathologic observations in two fatal cases. Silversides and Richardson in 1950 described one case and were able to collect seven cases from the literature. However, four of these cases represent two cases (A. F. I. P. Acc. No. 151166 and No. 163849) published in different articles.^{5, 6} Since that time four cases have been reported^{8, 11} bringing the total to 10 cases. Unpublished cases have been observed¹² and it is likely that this syndrome is more frequently associated with infectious mononucleosis than the few reported cases would indicate. The following is a report of such a case:

Report of Case

The patient, a 21-year-old white male Airman, was admitted to the Medical Service of Brooke Army Hospital March 12, 1952, as a transfer from Lackland Air Force Base Hospital. He had been in excellent health until February 28, 1952, when he developed sore throat and malaise. On the following day he noted numbness and tingling of his toes bilaterally. This progressed to the legs and thighs. On March 4 he developed slight difficulty in walking. Numbness and tingling of the fingers was noted on March 6. On that day the patient reported on sick call and was hospitalized at the Lackland Air Force Base Hospital. At that hospital examination revealed a red, edematous pharynx with flecks of white exudate; sluggish, deep tendon reflexes; active, superficial reflexes, and intact sensation to pain and light touch. His gait was unsteady, hesitant, widebased, and shuffling. He contracted all muscle groups well, but would exert little pressure with any group. Admission white blood count was 14,000 with 28 per cent neutrophils, 62 per cent lymphocytes and 10 per cent monocytes. Urinalysis was normal. Throat culture collected on the day of admission revealed beta hemolytic streptococcus and he was placed on penicillin. On March 10, serum heterophile agglutination was reported positive in a titer of 1:896 with a titer of 1:112 after Guinea pig kidney absorption. On March 11, lumbar puncture revealed a normal pressure, no cells, normal sugar and chlorides, and 190 mgm per cent total protein. During hospitalization the patient developed progressive paralysis of the extremities and left facial muscles. Sensation remained intact although he complained of marked paresthesia of the upper and lower extremities. On March 12, he was transferred to

*Resident in Internal Medicine, University Hospital, Augusta, Georgia.

Brooke Army Hospital with diagnoses of Infectious Mononucleosis and Guillain-Barre syndrome.

Past history and family history were non-contributory.

PHYSICAL EXAMINATION

Admission temperature 98.6 F; pulse 130/min.; blood pressure 134/88, and respirations 26/min. He was a well nourished, white male of mesomorphic habitus who complained of marked weakness. Except for tachycardia, circumoral pallor, shotty lymphadenopathy and an injected nasopharynx, abnormal findings were limited to the neurological examination. There was slight nuchal rigidity. The functions of Cranial nerves I through IV, VIII and XII were intact. There was facial diplegia with complete paralysis on the left and almost complete paralysis on the right. Phonation revealed a weak E sound and a nasal K sound. The gag reflex was absent and swallowing was poor. Indirect laryngoscopy showed bilateral partial paralysis of the vocal cords on proximation. There was marked weakness of the sternocleidomastoideus and trapezius muscles, intercostal and abdominal muscles. The diaphragm moved well and the paraspinal muscles showed good strength. There was almost complete paralysis of the extremities, most marked in the proximal musculature.

LABORATORY AND X-RAY FINDINGS

Admission white blood count was 19,300 with 70 per cent neutrophils and 30 per cent lymphocytes (19 per cent atypical lymphocytes of the Downey cell type). Hemoglobin was 18 gm. per cent and hematocrit 52 mm. Urinalysis and serological test for syphilis were normal. The white blood count fell gradually to 6,750 with 40 per cent neutrophils, 56 per cent lymphocytes, two per cent monocytes and two per cent eosinophils on April 11, 1952. Lumbar spinal fluid showed two cells (mononuclear), 85 mgm. per cent sugar, positive globulin test, 135 mgm. per cent total protein and a colloidal gold curve of 1112221000. Serum heterophile agglutination was positive in a titer of 1:2045. On April 2 lumbar spinal fluid showed 0 cells, 56 mgm. per cent sugar, positive globulin test and 80 mgm. per cent total protein. Chest X-ray on the day following admission was normal. Electrocardiogram on March 13 showed supraventricular tachycardia.

HOSPITAL COURSE

On the day of admission a tracheotomy was performed because of the partial vocal cord paralysis and weak cough with inability to clear respiratory tract secretions effectively. He was placed on 600,000 units of procaine penicillin daily for prophylactic purposes. On the second hospital day he was started on 25 mgm. of ACTH in 1000 cc. of five per cent glucose in water administered by slow intravenous drip over an eight hour period each day. He did well with frequent turning and suction until the third hospital day when he developed left costovertebral angle pain and a temperature of 102.0 F. On the fourth hospital day his temperature rose to 104.0 F., pulse to 190/min. and blood pressure to 170/90. At this time his respiratory movements began to weaken. Examination revealed slight cyanosis, rales and signs of consolidation at the left lung base posteriorly. He was placed in a Drinker respirator which he tolerated well. His pulse slowed to 135/min. and his color improved. Sputum culture revealed pseudomonas and coliform organisms insensitive to the usual antibiotics. On March 17 the intravenous ACTH was discontinued. At this time he became unable to swallow and received parenteral fluids and medication until March 20. Penicillin, sulfonamides, aureomycin and chloromycetin in large doses failed to dramatically affect the course of his pneumonitis. His temperature rose to 105.0 F. and remained near that level until March 22 when it began to fall by lysis returning to normal on March 30, 1952.

The tachycardia was persistent and did not vary with the temperature. Ten mgm. of meholyl subcutaneously slowed the pulse, but its effect was terminated by the administration of atropine because of the resulting marked bronchorrhea. The usual digitalizing dose of Cedilanid had no effect on the pulse rate. The pulse slowed gradually to 110/min. on March 30, then to 80/min. on April 15.

The first signs of neurological improvement appeared on March 18 with partial return of facial movement. On March 20, respiratory movements were markedly stronger and the patient was able to remain out of the respirator for short periods. He was able to swallow liquids on March 21. By

March 26, all cranial nerve functions were markedly improved. On April 2, the patient was able to raise himself in bed and could stand with assistance. He no longer complained of paresthesias. On this date the tracheotomy tube was removed and he was started on passive range of motion exercises by the Physical Medical Service.

He gained muscle strength gradually, and on May 7 was transferred to the Orthopedic Service where His Physical Medicine Program was increased. By May 19, he had fully recovered except for mild generalized muscle weakness. He was sent on a thirty day convalescent furlough. On return he was further improved. Following a period of Physical Reconditioning he was returned to full military duty on July 22, 1952.

Comments

Although the patient showed complete recovery five months after the onset of his disease, his condition was quite critical at the height of his illness. The persistent tachycardia was felt to be due to paralysis of the Vagus nerve with loss of its effect on the cardiac regulatory mechanism. ACTH and aureomycin appeared to exert no beneficial effect in this case. Stillman and Ganong¹³ reported the effectiveness of ACTH and cortisone in their case of Guillain-Barre syndrome of unknown etiology at the time this case was under observation. It was decided to use ACTH empirically in this case in hopes that it would halt the progression of the condition. Hubler et al¹ reported ACTH and aureomycin apparently ineffective in their case of encephalitis associated with infectious mononucleosis.

Summary

A case of Landry-Guillain-Barre syndrome associated with infectious mononucleosis is reported. In addition to involvement of the Spinal nerves, there were disturbances in the functions of Cranial nerves V, VI, VII, IX, X and XI. Recovery was complete five months after onset. ACTH and aureomycin appeared to exert no favorable effect on the course of the disease in this case.

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The Application of

DYNAMIC PSYCHIATRY to CLINICAL MEDICINE

Despite the increased interest in psychiatry in general and psychotherapy in particular by general practitioners, internists, and other specialists since World War II, there still remains considerable doubt in their minds as to the value, efficiency, and advisability of its use in the various disturbed emotional states which they so frequently see in their daily practice. It is felt that this remaining skepticism is due largely to their feeling that psychiatry operates on an extremely mystical and unscientific basis, and represents a peculiar conglomerant mixture of theory and technique. In this regard it is important to remember that to a large extent clinical medicine still operates at the level of an inexact science and that the so-called art of medicine continues to operate as an important factor. However, it is felt that this existing schism between psychiatrists and medical men in other specialties is largely the fault of the psychiatrists themselves.

Their deficiencies manifest themselves in two main directions; first, the use of an almost private vocabulary or jargon by dynamic psychiatrists which to a large extent excludes others from appreciating and understanding the work advanced by this "inner circle," and secondly the indiscriminate purely empirical use of electro-shock therapy by the more non-dynamic psychiatrists. That this latter problem exists cannot be denied but it is not the purpose of this paper to discuss this dilemma.

I hope instead to point out some of the ways in which psychotherapy can be of help to patients, and secondly to develop a rational explanation and description in understandable dynamic terms for these clinical improvements.

Perhaps the first step in this undertaking can best be accomplished by a description of case examples seen and treated by the author.

Report of Cases

CASE A: Mrs. B., 26 years old, was referred with complaints of severe intermittent debilitating headaches and dissatisfaction in her relationship with her husband. Because of fears of desertion, isolation, and rejection, the genetic basis of which is not pertinent to this paper, she had considerable difficulty meeting her husband's demands in a mature manner, and felt compelled to give in to his various desires be they exhortations regarding the scheduling of meals or demands of sexual submission.

It was soon learned by means of the interviews that to the extent the patient felt pressured by the demands of her husband, he represented her mother who also had made severe demands on her when she was a child. In this regard the connection between her unexpressed anger and her headaches was suggested and partially accepted. This new insight,

however, was not particularly beneficial to the patient, as far as her symptom was concerned, until an interpersonal situation of a similar nature represented itself to her in the therapeutic relationship. In a further effort to broaden and deepen her insight, I detected that because of this effort she felt as if she were being pressured by me to accept interpretations. This manifested itself by stubbornness and other forms of resistance, and at the same time she began to feel the same old resentment. When this phenomena was further discussed the patient was for the first time able to really appreciate and recognize her hostile feelings.

This additional insight on an emotional basis was initially frightening and followed by an exacerbation of symptoms. Soon thereafter, however, by means of this therapeutic experience she was able to learn that hostility could be expressed without dire circumstances, i.e., loss of support of the therapist (parent), and the headache symptom subsequently permanently cleared.

CASE B: Mrs. C., 36 years old was referred because of multiple somatic complaints which included right lower quadrant pain, painful urination, "asthma" and cancer phobia. Initially, so self depreciating was this patient that she was extremely reticent to talk, seeming to fear condemnation by the therapist. History revealed that her previous husband, against whom she had developed strong hostile impulses, had died of cancer. This was an extremely guilt producing event to the patient which had much to do with her self condemnatory attitude. After about 10 visits, however, the patient began to feel strong sexual attraction towards the therapist and at the same time became more comfortable in regards to her verbalizations. Soon thereafter the somatic complaints and cancer fears disappeared. This dramatic improvement was based on definite inter-related psychological factors which will be mentioned later.

CASE C: Mr. D., a 30-year-old clerk, was referred by a urologist because of persistent vague pains in the region of the genitals which were not relieved by suggestion or manipulation. It became apparent soon after the initial interview that his symptoms actually played a secondary role and were used as a means of making interpersonal contact. It was ascertained that from earliest childhood this patient had been severely rejected, frightened, and humiliated by his parents which had greatly impaired his emotional development. As he grew older he developed marked feelings of insecurity which resulted in his becoming a seclusive individual.

He also developed a peculiar speech impediment. One of the few pursuits in life from which he could derive some pleasure was the operation of an amateur radio set, the use of which had been considerably interfered with for four months prior to my seeing him because of increased frustrations in his emotional life. This inhibition lent itself particularly well to expressing and understanding his pathology in that just as he was about to send a message he would become anxious and block, fearing that he would be interfered with or interrupted, that he would make too many mistakes and thus expose himself to humiliation and, most of all, that no one would answer his message thus exposing himself to rejection which was so threatening.

After the first few sessions it was noted that he became more at ease, and during one session suddenly volunteered the following information, "I was surprised last evening to find that I could send (messages) again without much fear.

Another operator answered my call—we talked for an hour (the length of one therapeutic interview). I enjoyed the conversation and intend to call him again soon.” Thus we see that the therapeutic relationship not only diminished his anxiety to the point that he could again operate his set, but this device also served the purpose of communicating his feelings toward me i.e., “I enjoyed the conversation, etc.”

These examples help to show, I think, what can be accomplished in a relatively short period of time by the proper application of psychotherapeutic techniques. Of course improvement is not always so readily brought about in every case, nor does the improvement described in these cases indicate that their final termination or “cure” was near at hand. I should now like to further attempt to explain how these improvements came about, thus creating a more understandable basis for these results. A slight digression will first be advisable, however, so as to make the foregoing more lucid.

Earlier in the paper the term dynamic was used as an adjective denoting a particular approach to psychiatry. Let us see what some of the implications of this word are. First of all it denotes a constant movement of psychic forces in the form of fundamental hunger and sexual appetites and feelings toward outer expression. These wishes seek discharge for the purpose of gaining satisfaction or relief, etc. Opposing these primary needs for discharge are counter forces, which for the purpose of protecting the organism from the social consequences or imagined consequences which would result if discharge was allowed, bitterly contest against their expression. Thus the term dynamic is concerned with the interaction of counter forces. Where these counter forces are equal, i.e., where the strength of the discharge demands are neutralized by the strength of the demands external to these primary feelings, a conflict results and should this conflict continue a state of tension will develop according to the Homeostatic principle of Cannon.¹ As indicated by this principle, the fundamental nature of all living organisms is a striving to abolish tension and maintain a constancy or optimum level of excitation.

That part of the mental apparatus which functions so as to find a satisfactory solution to this conflict can for the purpose of this paper be termed a mediator. As stated by Fenichel,² all mental phenomena can be thought of as being composed of derivatives of original primary wishes which have been altered by the mediator by means of compromise efforts. Neurotic illness develops if and when the compromise solution to the conflict is not sufficiently satisfying to the organism as a whole, i.e., where an adequate amount of discharge is not allowed due to its being unduly blocked by counter forces.

It should be briefly added that these counter forces which originate from the external environment, beginning with the parents, sooner or later in childhood become incorporated into the organism. This seems self evident and necessary since the individual must in time learn to deal with various life problems requiring judgement by means of his own integrity and not solely by the pressures exerted from the external world, although these naturally influence the final judgements. However, this develop-

mental process means that the conflict which at first operated between inner wish and external counter demands now becomes one of inner wish and inner counter demands and thus becomes an “internal affair.” In this situation it becomes even more important for the mediator to find satisfactory solution and thus resolve the tension. Also the implication so far has been that the stimuli which bring about need for discharge and the counter forces always operate at the level of awareness. This is certainly not the case and often only the sense of tension and the vague accompanying uncomfortableness or fatigue, etc. is felt consciously. Thus these primary wishes may be blocked from awareness and express themselves in the form of symptoms. To the extent that the mediator is able to find socially acceptable means of granting discharge or expression in adequate amounts, mental health will be maintained. When this quantitative and qualitative solution is not reached and tensions build, neurotic symptoms or inappropriate behavior results. This later situation is commonly observed where a relatively insignificant event will e.g., precipitate an excessive rage reaction. Such overreactions are the observable end result of an unsatisfactory handling of conflict and/or tension.

In time the warded off wishes and feelings which have been blocked and pushed below the level of awareness lose their verbal expression. However, parts and pieces of them remain in the form of remotely connected memories, ideas and symptoms. It is the function of the psychotherapy to encourage the expression of these memories and ideas which gradually, as the blocks are removed, become more closely connected to the original conflict material. It should be made clear, however, as Jones⁴ has stated that “Neurosis does not reside in the material that is repressed so much as in the fact that it is repressed.” Thus, until the patient gains courage to give up his defenses and lift the repressions, no opportunity for emotional growth can result. This oversimplification of Freudian principles, although inadequate and incomplete should be helpful now to further understand the results obtained in the previously mentioned cases.

In *Case A*, the wish which was striving for discharge was related to her early hostile feelings towards her mother while the counter forces at work were motivated (1) by her fears of retaliation in terms of isolation, and rejection and (2) by her more basic fears of hurting or killing the mother in accordance with her own hostility. Thus the mediating mechanism dealt with this conflict by creating a personality state characterized by submission and deference. However, this compromise was not entirely satisfactory in that it was experienced by her as being too weak a personality and too humiliating a solution. Therefore periodically hostile impulses would be experienced in the form of feelings of resentment, hence her dissatisfaction with her husband. Under other circumstances hostile feelings would break through despite the counter efforts by the mediator which resulted in increased feelings of threat and fear. Under these circumstances solution became available only in the form of painful head-

aches in which the solution was expressed in terms of "safer to hurt oneself than hurt others." This phenomena became clear when in the therapeutic situation the patient was able to see how her hostile feelings towards the doctor (representative of husband, mother) could precipitate headaches. It also shows that the removal of this symptom operating at a relatively superficial level, does not imply "cure." There remains the problem of finding more adequate and acceptable means of expressing her hostility, but she was now much farther along in finding this solution by her now being able to recognize and accept the presence of these emotions.

In *Case B*, we see a patient who very early in therapy was able to give up her somatic symptomatology when she gained expression to hostile feelings. To a large extent this was accomplished by means of the therapist's accepting attitude and timely interpretations through which she was able to lose sufficient amount of fear to talk about her anger against these important people in her past and present life which included mother, sister, deceased husband and present husband. As these expressions increased to the point of hatred, an accompanying feeling of expression of love toward the therapist was also developing. This splitting of positive and negative feelings has interesting implications. In my presence the patient felt secure to condemn others and thus no longer had need to resort to the previous compromise solution, in reference to her feelings of hate, (i.e., the somatic symptoms). But what of these developing erotic feelings and desires? Did this not but serve the purpose of further reassuring her of my continued presence and support? And furthermore, what better protection could she have when hostile feelings towards me would press for expression. This was an inevitable situation since, as I became more important as a means of support and protection, more and more demands would be made which must ultimately and eventually result in disappointment, feelings of rejection and accompanying resentment and hatred. Thus the use of erotic feelings to deny their opposite effect was a second important motive for these expressions of "love." The mediator then used this loving adoring child-like personality as a counter force. Actually it took considerable time before the patient could become mature enough and secure enough to see and appreciate the real hostile feelings felt towards me (representative of mother), the recognition of which also resulted in a brief exacerbation of her somatic symptoms. It should be mentioned that this patient had been seen by several physicians over a four year period prior to this, re: her physical complaints. Towards some of these physicians she had developed similar positive feelings but because there was no opportunity for expression of these emotions, little symptomatic improvement could be effected.

In *Case C*, the patient developed difficulty communicating or interacting with the outside world even by the remote means of an amateur radio set. We can understand this withdrawal best if we can visualize how the patient felt when he considered himself rejected or ignored by others. Under these circum-

stances, he would feel furious to the point of committing murder. The violence of his hostility, which had its origins in infancy, based on the premise of considering those people as *being* "bad" who had caused him to *feel* badly, and similarly to *hurt* those who had hurt his *feelings*, was extremely anxiety producing to him. Thus the mediator was hard pressed to regulate the degree to which it was safe to expose himself to the outside world. As he became more and more used to withdrawing interest in others, he became increasingly more sensitive to and preoccupied with himself and his symptoms. On the other hand his symptoms could be utilized as one of the few remaining modes by which he could maintain contact with others and thus protect him from more profound withdrawal. Thus while he was not operating at a high level of integration, nevertheless constant security operations, as Fromm-Reichman³ has called them were being utilized to preserve sanity and prevent violence.

Thus when through the interviews the patient felt safe to develop further interest in the outside world through his relationship with the therapist he was able to give up some of the primitive forms of control such as his somatic symptoms, preoccupations and excessive fears and timidly reach out again towards others. The therapeutic relationship represented a new and corrective experience in which he could again communicate on an equal basis with another human being with greatly diminished fear of emotional injury.

The establishment of this state of equanimity by these means was an indispensable step in further dealing with this patient's disturbed emotional state.

Summary

This paper has endeavored to point out some of the ways that psychotherapy can be utilized to successfully manage symptomatology refractory to other forms of treatment. The emotional origin and nature of these types of disorders has been illustrated by case examples and a rational explanation of the results obtained has been advanced. A brief introduction to dynamic psychiatric principles has further been offered.

It has been suggested that some of the reasons for the lack of understanding and confidence which has developed in the minds of other practitioners towards psychiatry has been to a large part due to the extremely technical and complicated nature of psychiatric writings. This situation has markedly interfered with the appreciation of the efforts and contributions that dynamic psychiatry has made and can make to the general field of medicine. It is hoped that through this type of communication a closer relationship between psychiatrists and other medical specialists can be established.

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SYNCO PAL SEIZURES *in*

RECUMBENT POSITION

in LATE PREGNACY

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An obstetric case is presented because of the unusual syncopal seizures which occurred during the last month of pregnancy with the patient in the recumbent position. I can recall only a single episode in one other patient, which lasted but a few seconds and did not recur.

Report of Case

The patient was a small white primipara, 22 years old. She was about five feet tall, and her normal weight was about 104 pounds. She experienced a normal and uneventful pregnancy until the last month. Under the care of a physician in another state where her husband was a student, she worked in the library of the college, gaining only about 15 pounds and feeling well all the time she was there. At the beginning of the last month of pregnancy she returned home for delivery and came under my care.

The first sign of anything unusual was on April 27, 1952, exactly one month before the expected date of delivery. At that time she fainted in church, but the faint was thought to be due to the excessively high temperature of the room. She recovered in a short time. The next day she consulted me for the second time. I had seen her previously at Christmas when she was home for the holidays. On this date, April 28, she appeared normal. The blood pressure was 118 systolic and 80 diastolic. The weight was 118 pounds. Urinalysis gave negative results. When I saw her one week later, all appeared to be well, but she had gained two pounds.

On May 12, a vaginal examination disclosed that the cervix was dilated about 3 cm., but with no effacement. When I remarked to the patient that I believed she was in labor and did not know it, she suddenly began to feel faint and nervous, and her pulse became accelerated. At the time she was lying on her back on the examining table. The nurse and I moved her to a bed and let her rest. A few minutes later, when summoned by the nurse, I was startled to find her skin cold, damp, and clammy; I could not feel a pulse or obtain a blood pressure reading, nor could I hear any fetal heart tones. We placed her on her side, and in three or four minutes the blood pressure returned to 118 systolic and 70 diastolic and the pulse rate to about 90. She remained in bed for several hours on her side with no recurrence of shock symptoms. In the afternoon she was able to walk to the car and go home. She went about as usual during the succeeding days except that she could not lie on her back as the weakness would recur each time.

To complicate matters, on a second vaginal examination a few days later, I thought that a hand was in front of the head, although a roentgenogram on April 28 looked normal. When the patient was in the recumbent position, the pulse rate would increase to 160 to 180 per minute, and the blood

pressure would drop to 90 systolic and 80 diastolic, or even to 80 systolic and 70 diastolic in each arm. The instant she would turn on her side or get in any other position, the pulse rate and the blood pressure would return to normal. This change happened so rapidly that it could not be of psychic origin, and it happened too often also.

She became so uncomfortable that on May 21 I decided to observe her closely in different positions, repeat the roentgen and the vaginal examinations, and recheck the behavior of the pulse and the blood pressure. On May 23, roentgen examination gave no evidence of a hand in front of the head, and on vaginal examination nothing was felt in front of the head. There was cervical dilatation of 3 cm., and she was, in my opinion, definitely at term, and with an adequate pelvis.

After she was placed on the delivery table, the head was elevated as high as it would go. In a minute or two the pulse rate was 160 and the blood pressure 90 systolic and 70 to 80 diastolic. The second she would turn on her side, the pulse rate would become 65 and the blood pressure 120 systolic and 70 diastolic. This shift was tried several times with the same results each time.

It was decided then to rupture the membrane, thereby inducing labor, with the hope that this procedure might alter the pressure which was believed to be causing the circulatory phenomena. Should it not change, she would be delivered on her side or in a squatting position.

It all worked out satisfactorily, for a good quantity of fluid was passed and good contractions set in at once. At the end of two hours she could lie on her back with no changes in the pulse rate or blood pressure, both of which were checked frequently. She was delivered in the normal position in exactly four hours from the time the membranes were ruptured. She received 1½ cc. of demerol and nitrous oxide and oxygen. The baby was alert and apparently normal in every way.

DISCUSSION

WILLIAM B. FACKLER, JR., M.D., LaGrange, Ga.—History taken from Dr. Arnold's patient revealed no difficulty with syncope prior to pregnancy and indicated her to be an intelligent, emotionally stable person. Physical examination and ECG showed no evidence of cardiac abnormality. When she was put into the supine position she became aware of a "heavy, pulling, uncomfortable" sensation in the lower abdomen. Within ten minutes the sequence of events described by Dr. Arnold ensued but were prevented from progressing to syncope by changing her position. ECG during this time confirmed the obvious probability that the tachycardia developed via a sinus mechanism.

A similar primagravida was reported in 1948 by Clemetson.¹ In that instance syncope disappeared not only in the side position but also in the dorsal position when the uterus

was raised from the posterior abdominal wall. Seven weeks after supravaginal hysterectomy, external pressure directed toward the posterior wall would reproduce syncope.

In Dr. Arnold's patient it would seem that a gravid uterus, small stature, a previously unstretched abdominal wall and the supine position combined to exert an unusual degree of pressure. Several mechanisms whereby such pressure could produce syncope have been described: (1) vasovagal syncope resulting from unpleasant abdominal sensations,² (2) a summation of (1) and pooling of blood distal to the area of pressure on the inferior vena cava,³ (3) stimulation of pressure-receptor end organs in the abdominal aorta similar to those known to exist in the carotid sinuses.^{1,4} Our observations do not indicate which mechanism dominated in this patient. It

may be significant, however, that clinical features developed in a reproducible order, namely, tachycardia, then blood pressure changes, then premonitory symptoms of fainting and, finally, syncope. Both this sequence of events and the rapidity with which symptoms disappeared once pressure was removed suggest that interference with venous blood return played an important role.

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INTERCOSTAL NERVE BLOCK

with EFOCAINE *in the Management of the*

POST-THORACOTOMY *Patient*

M. BEDFORD DAVIS, JR., M.D., and LESTER RUMBLE, JR., Atlanta

If one were to attempt to design a procedure which would produce atelectasis, it would be difficult to surpass the conditions resulting from the extended use of great amounts of opiates to control postoperative thoracic pain. Morphine, as well as the other narcotic agents, is particularly useful for immediate postoperative period for the central nervous system depressant effects which serve to combat the psychologic trauma of the surgery. However, these agents are also well-known respiratory depressants, and in the larger dosage administered during the longer period required as a pain-control measure, they frequently serve to provide the atelectic "coup de grace" to the patient.

Atelectasis is a common pulmonary complication following thoracic surgery, and the loss of the ability to cough effectively is a significant predisposing factor.¹ Secretions, which are normally removed by coughing and ciliary action, remain in the lungs to produce a lobar or lobular obstruction. Pain also

splints the chest both through reflex inhibition of respiration² and psychologic interference with deep breathing and coughing. Free motion is also limited by the presence of pain, and this, too, leads toward pulmonary and vascular complications as well as to prolong the morbidity.

There have been many methods suggested for the clearing of the tracheobronchial tree. These range from the intravenous injection of such agents as paraldehyde³ and Nikethamide⁴ to rolling the patient from side to side with vigorous back slapping.⁵ Endotracheal catheterization⁶ with suction is also frequently resorted to. The optimum procedure is to enlist patient cooperation in deeper breathing and coughing and with early ambulation regimens. These may be readily accomplished by effective postoperative wound analgesia.

The recent introduction⁷ of Efocaine*, a local anesthetic solution having a duration of approximately two weeks, permits the extended blockade of the nerves innervating a surgical area. This drug consists of procaine and butyl aminobenzoate in a

*E. Fougera & Co., Inc., New York, N. Y.

non-oily, aqueous-miscible solvent. When the solution is injected, the contact with body fluid causes a precipitation of the anesthetic bases. These anesthetic agents are then slowly absorbed from the drug depot, and thereby exert their effect for the extended period.

This concept for prolonged anesthesia has been clinically established by many investigators for a wide range of surgical practice. Iason and Shaftel^{8,9} reported their experiences with this agent in a series of almost 600 major surgical patients. They found this drug to markedly reduce postoperative pain and to virtually eliminate the need for the stronger narcotics. Tucker,¹⁰ and Gross and Shaftel,¹¹ described the role of Efocaine for postoperative anorectal pain control, while Perrin¹² used it to control the pruritic dermatoses. Penn¹³ reported this drug an efficient means of combating the pain following tonsillectomy, and Cappe and Pallin¹⁴ were able to provide adequate, prolonged perineal pain relief following episiotomy.

Deaton and Bradshaw,¹⁵ Chamberlain and Daniels,¹⁶ and Boere¹⁷ reported the effectiveness of this agent in controlling postoperative thoracic pain. This report describes our experiences with Efocaine for the control of postoperative pain following thoracic surgery.

A series of 25 patients, who were candidates for elective thoracic surgery, were injected with Efocaine as a means of postoperative pain control and a corresponding number served as controls. The drug was used for intercostal nerve block, and 1 to 2 cc. was injected about each indicated nerve.

Each thoracic nerve emerges from the intervertebral foramen, and divides into an anterior and posterior primary division after having first given off the meningeal nerve to the dura and vertebrae. The posterior primary division supplies the muscles and

the skin of the back; the anterior division gives off the ramus communicans to the sympathetic ganglion and then passes into the paravertebral space. The thoracic nerves (Fig. 1), as they emerge from the intervertebral foramen, lie midway between the transverse processes of the vertebrae. These nerves pass toward the rib immediately above and enter the intercostal groove. The intercostal nerves run forward in an oblique direction to innervate the skin and muscles of the thorax and upper abdomen. By placing the anesthetic solution about the appropriate nerves, pain sensations arising from the innervated area may be blocked for prolonged periods.

The injection of Efocaine (Fig. 2) was carried out at the conclusion of surgery before primary suture. The intercostal nerves may be readily located by direct vision and accurate placement of the drug is readily accomplished. In the cases of the lateral thoractomy, the needle is inserted from outside the rib-cage through the intercostal muscle, using both the eye and the index finger of one hand inside the pleura, as a guide. When the needle tip is visible and palpable just beneath the parietal pleura in the vicinity of the indicated nerve, 1 to 2 cc. of the drug are injected. The pad of muscle through which the needle has passed acts to seal the puncture preventing leakage of drug. Massage with the finger is then carried out to aid in spreading of the solution along the costal groove in order to avoid pooling.

The nerves to be injected will depend upon the extent of surgery. It should be noted that for effective pain control, the nerves both above and below the incision must be blocked. Where a partial blockade is obtained because an inadequate number of intercostal nerves are injected, a higher incidence of postoperative medication is required. Conversely, a too extensive intercostal blockade will reduce the effectiveness of the cough. Blocking the two nerves both immediately above as well as below the incision is a general rule, although this is not always applicable.

Caution should be exercised to avoid backflow of the solution into the superficial tissue as well as to prevent an intrapleural injection. When injecting close to the transverse process, care must be taken to avoid intrathecal placement of the drug. It should be remembered that prolongations of the dura surrounding the emerging nerve are known to extend for some distance from the spinous process. In the rare individual these dural extensions have been observed to project for several centimeters and unless special care is taken an accidental intrathecal injection will ensue. Aspiration before injection as well as exact location of the needle-tip both visually and by palpitation, will serve to eliminate this complication. Efocaine is contraindicated for intraspinal use. If fluid is aspirated, withdraw the needle and apply pressure for a minute or two and reinsert some distance away. Accurate placement is essential since there is little diffusion from the microcrystalline drug repository. Do not inject the drug into the nerve but about it.

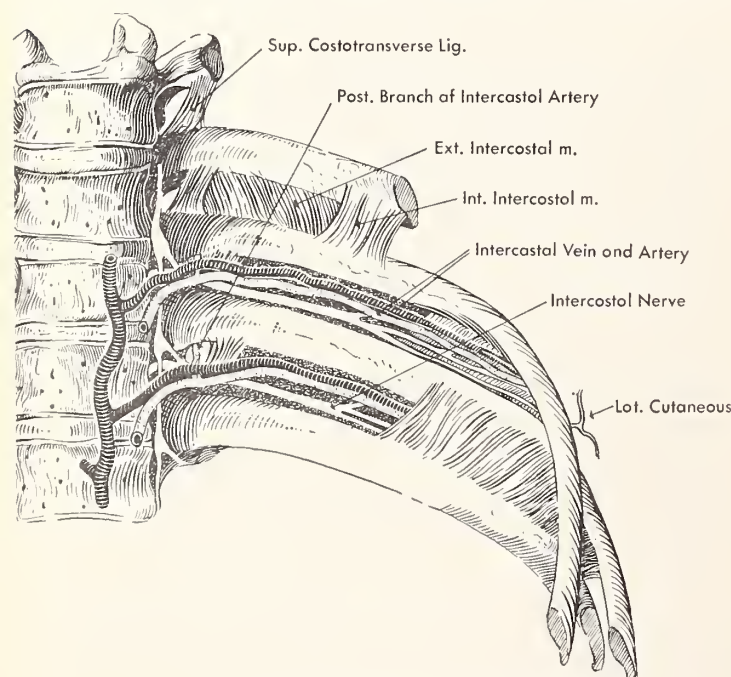


Fig. 1. Anatomy of Intercostal Nerves

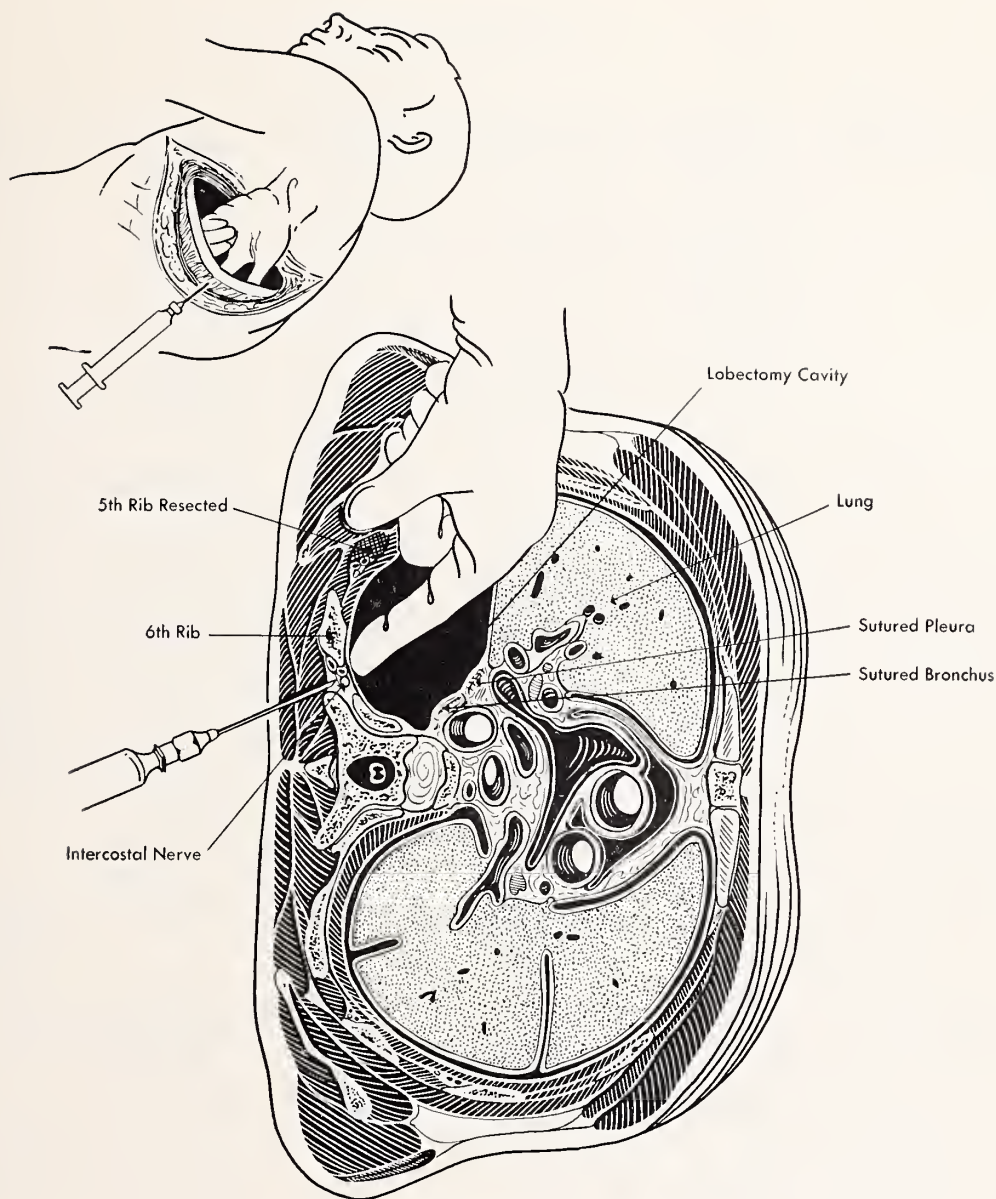


Fig. 2. Technique of Injection

The results of our first series are presented in Tables 1 and 2. Postoperative narcotics were not restricted and the same "pro-renata" orders were written for both the control and test patients. The effects of Efocaine were readily apparent in the treated group in spite of rather similar doses of narcotics being given to the two groups reported. These patients readily turned in bed under their own power. None assumed the rigid immobile dorsal position seen all too frequently in post-thoractomy patients. All coughed effectively and adequately from the time consciousness was first regained. The only post operative bronchoscopy required was in a very emaciated, apprehensive patient who had severe bilateral bronchiectasis and this was anticipated prior to surgery.

In spite of ad lib administration of postoperative

narcotics the quantities required by the treated group were somewhat less than the control group which indicated a greater degree of comfort. It must be remembered that certain "modes" in postoperative drug administration have been developed during the years because of the acute pain. In the first days following surgery, narcotics are administered at the "drop of a symptom." In fact, so accustomed are we to expect intense pain that routine narcotic orders are written. The actual drug needs of the treated group may best be demonstrated by the requirements of one blocked patient in which postoperative narcotics were carefully controlled to the individual need. This patient required only 10 mgs. of morphine the first day and was adequately managed with aspirin through convalescence.

Table 1
CONTROL SERIES

<i>Case</i>	<i>Age Sex</i>	<i>Diagnosis</i>	<i>Operation</i>	<i>1st PO Day</i>	<i>2nd PO Day</i>	<i>3rd PO Day</i>	<i>Complications</i>
E. S. W.	60/F	Carcinoma	Left Upper Lobectomy	MS 50mgm	MS 40 mgm	MS 30mgm	Bronchoscopy, 1st PO Day
J. B.	49/F	Carcinoma	Exploratory Thoracotomy	MS 60mgm	MS 50mgm	MS 30mgm	None
L. L. E.	40/F	Bronchiectasis	Right Middle Lobectomy Plexectomy	Pant 80mgm	Pant 60mgm Lum. 120mgm	Pant 80mgm Lum. 180mgm	None
J. T. W.	47/M	Carcinoma	Exploratory Thoracotomy	MS 50mgm	MS 40mgm	MS 20mgm	None
J. C.	35/M	Post-op Rt. Upper Lobectomy	First State Thoracoplasty 3 Ribs	Pant 100 mgm	Pant 100mgm	Pant 120mgm	Still on Pant. 20mgm every six hrs. on 11th PO day
M. S.	44/F	Carcinoma	Right Lower Lobectomy	MS 20mgm	Demerol 150	Demerol 75mgm	N and V for 24 hrs. Bronchoscopy on 2nd PO Day
M. A.	52/M	Carcinoma	Left Pneumonectomy	Dem 700mgm	Dem 500mgm	Dem 400mgm	Bronchoscopy 2nd PO Day
R. P. S.	53/F	Congenital Cyst	Rt. Lower Lobectomy	Pant 120mgm	Pant 120 mgm	Pant 120mgm	None
J. McG.	48/M	Carcinoma	Right Pneumonectomy	MS 20mgm Pant 80mgm	Pant 80mgm	Pant 80mgm	Auricular Fibrillation 1st PO Day. Bronchoscopy 1st PO Day
G. L.	27/F	Bronchiectasis	L. L. Lobectomy Lingulectomy	Dem 375mgm	Dem 450mgm	Dem 1225mgm	None
R. E.	43/F	Carcinoma	Pneumonectomy	Dem 150 mgm Pant 80mgm	Pant 100mgm Lum. 180mgm	Pant 60mgm Lum. 180mgm	None
J. W.	61/M	Carcinoma	Lobectomy Emphysema	MS 15mgm Dem 100mgm	Dem 250mgm	Dem 150mgm	Tracheotomy 2nd PO Day for excessive mucous and failure to cough
M. C.	46/M	TBC	Lobectomy	Dilaudid 15mgm	Dilaudid 15mgm	Dilaudid 2mgm Dem 300mgm	None
C. J. A.	51/F	TBC	R.U. Lobectomy Segmental resection, lower	Dem 500mgm Dilaudid 2mgm Lum. 300mgm	Dilaudid 10mgm	Dilaudid 6mgm Dem 225mgm	None
E. S. S.	43/M	Carcinoma	Exploratory Thoracotomy	Dilaudid 10mgm	Dilaudid 8mgm	Dilaudid 6mgm	None
M. W.*	47/F	Carcinoma Right Lung	Pneumonectomy Anterior	MS 30mgm	MS 20mgm	MS 30mgm	None
J. C. A.	50/M	Carcinoma Right Lung	Pneumonectomy Anterior	MS 30mgm	MS 60mgm	MS 45mgm	None
J. C. H.	42/M	Lung Abscess	L. L. Lobectomy Lingulectomy Lateral	MS 60mgm	MS 90mgm	MS 45mgm	Postop. Atelectasis Requiring Bronchoscopy Empyema
R. H.*	52/M	Carcinoma of Esophagus	Esophageal Resection	-----	-----	-----	Bilateral Serous Pleural Effusion
R. W.	22/M	Severe Asthma	Plexectomy & Sympathectomy	Dem 600mgm	Dem 600mgm	Dem 600mgm	Severe Asthma Postop Bronchoscopy Required.
R. L.	27/M	Tuberculous Empyema	Decortication Left Lateral	MS 60 mgm	MS 60mgm	MS 60mgm	Postop. Atelectasis with Bronchoscopy Required
T. P.	25/M	Bilateral Bronchiectasis	L. L. Lobectomy Lingulectomy Lateral	MS 60 mgm	MS 60mgm	MS 60mgm	Bronchscopy Required 3 Times
M. R.	23/F	Tuberculosis	Left Lower Lobectomy	MS 60 mgm	COD 120mgm	Aspirin 60 gr.	None
M. T.	39/M	Tuberculoma	Wedge Resection Lateral	MS 60 mgm	MS 60mgm	MS 60mgm	None
R. L.	23/M	Tuberculosis	Left Upper Lobectomy	MS 60 mgm	MS 60mgm	MS 60mgm	None

Table 2

RESULTS OF INTERCOSTAL NERVE BLOCK WITH EFOCAINE

<i>Case</i>	<i>Age</i> <i>Sex</i>	<i>Diagnosis</i>	<i>Operation</i>	<i>Nerves</i> <i>Blocked</i>	<i>1st PO Day</i>	<i>2nd PO Day</i>	<i>3rd PO Day</i>	<i>Complications</i>	<i>Comments</i>
M.L.T.	50/F	Tuberculoma	Wedge Resection Anterior Incision	345	MS 10mgm	MS 30mgm	MS 40mgm	None	Fairly good. Area of analgesia inadequate.
C.N.	27/M	Broncho-pleural Fistula	Decortication Excision Bullae Vagotomy Lateral	34567	MS 15mgm	MS 45mgm	MS 10mgm	None	Excellent
T.P.D.	57/M	Carcinoma Left Lung	Exploratory Thoracotomy Lateral	34567	MS 20mgm	MS 50mgm	MS 30mgm	None	Very good
E.T.D.	47/M	Carcinoma Left Lung	Exploratory Thoracotomy Anterior	12345	Pant 10mgm	Pant 10mgm	Pant 24mgm	None	Excellent
C.E.W.	36/M	Bronchiectasis	Middle Lobectomy Anterior	345	MS 60mgm	MS 60mgm	MS 70mgm	None	Poor
H.L.H.	49/M	Carcinoma Left Lung	Exploratory Thoracotomy Lateral	34567	COD 30mgm	MS 10mgm	MS 10mgm	None	Excellent
L.R.O.	36/M	Bronchiectasis	Left Lower Lobectomy Lateral	45678	MS 30mgm	MS 20mgm	MS 2mgm	Persistent Hiccough	Excellent
W.E.S.	56/M	Granduloma	Left Upper Lobectomy Lateral	2345678	MS 40mgm	MS 40mgm	MS 30mgm	None	Good. Paralysis of Chest Wall Musculature Seemed to Reduce Effectiveness of cough.
F.T.	27/F	Bronchiectasis	Right Lower Lobeectomy Lateral	34567	MS 40mgm	Demerol 500mgm	Demerol 200mgm Dilaudid 3/32 gr.	Acute Asthmatic Attack 1st 5 days PO	Fairly good
L.W.	26/F	Patent Ductos Arteriosus	Ligation Ductos Arteriosus Lateral	34567	Dem 300mgm	Demerol 400mgm	Demerol 400mgm	Mild Neuritis of Intercostal Nerves	Fairly good
R.A.M.	53/M	Bronchiectasis with Hemorrhage	Left Lower Lobectomy Lateral	34567	MS 30mgm	MS 30mgm	MS 10mgm	Auricular Fibrillation 2 days PO	Good
W.W.M.	27/M	Bronchiectasis	Right Lower Lobeectomy Lateral	456789	MS 10mgm	MS 20mgm	MS 40mgm	Postop Atelectasis Requiring Bronchoscopy	Poor
J.B.	28/F	Bronchiectasis	Middle Lobectomy Anterior	123456	MS 10mgm	MS 24mgm	MS 8mgm	Minor Wound Infection	Good
J.B.	24/F	Emphysema Broncho-Pleural Fistula	Wedge Resection Right Upper Lobe Anterior	12345	MS 10mgm	MS 30mgm	MS 20mgm	None	Excellent
C.V.D.	24/M	Pulmonary Tuberculosis	Resection Segments Anterior	12345	MS 10mgm	MS 30mgm	MS 24mgm	None	Good
T.C.	24/M	Pulmonary Tuberculosis	Wedge Resection Anterior	1234	MS 10mgm	-----	-----	None	Excellent
M.R.*	20/M	Mediastinal Cyst	Removal of Mediastinal Cyst Anterior	12345	MS 10mgm	MS 10mgm	-----	None	Excellent
C.T.*	53/F	Aneurysm Innominate Artery	Cellophane Wrapping Tracheotomy Anterior	12345	MS 10mgm	MS 20mgm	MS 10mgm	Wound Infection Requiring Secondary Closure	Good
G.R.	33/F	Carcinoma	Exploratory Thoracotomy Lateral	45678	MS 40mgm	MS 10mgm Pant 60mgm	Pant 80mgm	None	Good Cough Cooperation

Table 2

RESULTS OF INTERCOSTAL NERVE BLOCK WITH EFOCAINE—(Continued)

Case	Age Sex	Diagnosis	Operation	Nerves Blocked	1st PO Day	2nd PO Day	3rd PO Day	Complications	Comments
C.B.	M/60	Carcinoma Emphysema	Right Upper Lobectomy Lateral	56789	MS 50mgm	MS 40mgm	MS 50mgm	None	No Noticeable Decrease in Pain
R.V.C.	61/M	Emphysema	Pulmonary Plexectomy Excision of Blobs Lateral	45678	MS 60mgm	MS 50mgm	MS 40mgm	None	Good Cough
J.L.N.	53/M	Esophageal Stricture	Esophageal Resection Lateral	6789	MS 40mgm	MS 40mgm	MS 40mgm	Deceased 13th PO Day Massive Pulmonary Embolus	Good Cough Cooperation
R.V.A.	56/M	Carcinoma	Exploratory Thoracotomy	12345	MS 40mgm	MS 30mgm	MS 10mgm	None	Good Result
J.B.D.	49/M	Granuloma	Segmental Resection LU and LL Lobes Lateral	34567	MS 40mgm	MS 30mgm	MS 10mgm	Air Leak Sealed in 24 hours	Good Result
J.C.	19/F	Tuberculosis	Right Lower Lobectomy Lateral	34567	MS 10mgm	MS 40mgm	MS 20mgm	None	Good Cough

The following cases serve to illustrate the typical postoperative course following intercostal nerve block with Efocaine:

Report of Cases

The following cases serve to illustrate the typical postoperative course following intercostal nerve block with Efocaine:

Case, J. B.: This 24-year-old female was admitted to Georgia Baptist Hospital, April 17, 1952, with a diagnosis of spontaneous pneumothorax with persistent bronchopleural fistula. After ten weeks previous on a medical regime without improvement she was referred for surgery. On April 19, 1952 a thoracotomy was performed, using an anterolateral incision and entering the pleura through the third interspace. A small area of emphysema was found in the apex from which air leakage could be demonstrated. A wedge resection of the area of emphysema seemed practicable and was carried out. Two thoracotomy tubes were inserted into the pleural space. Intercostal nerves 1 through 5 were injected as far posteriorly as possible with 1 cc of Efocaine. The chest was then closed in the routine manner. The postoperative course was uncomplicated. Temperature was normal after three days. The patient was out of bed the first postoperative day. The fourth day she requested permission to take a short ride in an automobile. The lung re-expanded well. No fluid formed after thoracotomy tubes were removed the second postoperative day. She was dismissed from the hospital on the eighth postoperative day. She had very little pain in her operative site during the first few days after surgery and required no analgesics at home after discharge from the hospital.

Case R. A. M.: This 53-year-old printer was admitted to Saint Joseph's Infirmary because of sudden onset of massive hemoptysis following exercise on the afternoon of admission. X-rays revealed some emphysema bilaterally, but little else. Bleeding continued in small amounts in spite of all the usual conservative measures. Bronchoscopy done the third day of hospitalization revealed the blood was coming from the left lower lobe. Specimens taken were negative for tumor. Exploratory thoracotomy was undertaken after 10 days of continuous hemoptysis with a tentative diagnosis of bronchiectasis. A left lateral thoracotomy was performed, the chest being entered through the fifth interspace. A complete adhesive pleuritis was present and adhesions were freed by sharp dissection. Then it was noted that the major fissure was completely absent. The lower lobe revealed no evidence of tumor. Resection of the lobe was carried out, the diagnosis

still being bronchiectasis, which was later confirmed by the pathologist. The procedure was difficult and prolonged. The intercostal nerves, 3 through 7, were injected with 1 cc of Efocaine. Postoperatively the patient developed auricular fibrillation. This produced considerable apprehension and for this reason he received several 10 mg. doses of morphine which were not needed for pain. The fibrillation responded to quinidine on the third day after surgery and the patient required only 10 mg. of morphine the entire 24 hours. He coughed well postoperatively and was eager to get out of bed as soon as his cardiac condition cleared. He was discharged the eighth day after surgery. Aside from a small apical pocket of fluid which required aspiration no further complication developed.

These cases serve to demonstrate also that the quantities of postoperative medication required may not always be based upon postoperative pain. Certainly we do not mean to imply that morphine is of no importance to the postoperative regimen where indicated. However, unless specific needs arise, respiratory depressants should not be routinely administered for pain control when other more efficient non-narcotic techniques are available.

The postoperative complications observed in the treated series were not unique and have all been encountered prior to the use of prolonged local anesthesia as well. It is significant, however, to note the dramatic reduction of the occurrence of atelectasis and the need for postoperative bronchoscopy.

The use of Efocaine is considered a safe, effective means of non-narcotic pain control for the post-thoracotomy patient, and will contribute considerably to the reduction of the postoperative morbidity of the patient. The presence of productive coughing facilitated clearing of the tracheobronchial tree in this series of cases, thereby reducing the need for bronchoscopic aspiration and virtually eliminating postoperative atelectasis.

Summary and Conclusions

1. A means of non-narcotic postoperative pain control for the post-thoracotomy patient utilizing

intercostal nerve block with Efocaine is described.

2. This technique afforded the patient a high degree of comfort in most cases, permitted free motion, and facilitated coughing, thereby virtually eliminating postoperative atelectasis.

3. Intercostal nerve block with Efocaine seems to be a desirable means of pain control and further study in its use is certainly justifiable.

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BARIUM PERITONITIS

HERBERT M. OLNICK, M.D., Macon, and

WILLIAM M. WATKINS, M.D., Dublin

The escape of an appreciable quantity of barium sulfate into the peritoneal cavity during a Roentgen diagnostic procedure is an uncommon clinical experience. Cases with obvious perforation of the intestinal tract are not given barium but are clear cut surgical emergencies. In other cases, the alert radiologist ceases the administration of the barium when the leak is detected.

The purpose of this paper is to record our encounter with a patient who, five years previously, had been given a barium meal, apparently during a perforation of his chronic duodenal ulcer. The quantity of barium which entered his free peritoneal cavity was of such magnitude as to make his outcome and present X-ray films of dramatic interest.

Case Report

The patient, Mr. F. C., is a 37-year-old white male who had had fairly typical symptoms of a peptic ulcer for 12 years. The symptoms had exacerbated recently and he was referred for an X-ray examination of his upper gastrointestinal tract.

Fluoroscopic screening of the abdomen revealed a large amount of opaque material disbursed throughout the entire abdomen. An abdominal film was taken (Fig. 1) which showed streaky and conglomerate deposits, obviously barium, in the right lumbar gutter extending up over the liver and dispersed irregularly throughout the remainder of the peritoneal cavity. Some of the barium deposits are in rounded collections suggesting lymph node deposits.



Fig. 1. Extensive intraperitoneal barium extending above dome of the liver (see arrow). Some of the nodular shadows may represent lymph node deposits.

The examination of the gastrointestinal tract revealed a typical peptic ulcer clover leaf deformity of the duodenal bulb. (Fig. 2) Diminished and sluggish peristalsis of the stomach and small intestine was noted and this was presumed to be on the basis of extensive adhesions.

A more detailed history revealed that this patient had been hospitalized near his home five years ago, at which time he



Fig. 2. Gastrointestinal series shows typical peptic ulcer clover leaf deformity of duodenal bulb (see arrow).

had acute symptoms suggestive of a perforating ulcer. He was given a barium meal without fluoroscopy and films were obtained. These films are unfortunately no longer available. No surgery was performed. He stayed in the hospital for 17 days and under conservative treatment made a fairly uneventful recovery. At no other time up till the present examination had he ever been given any other type of barium study, either by mouth or rectum. He has never had any complaints to suggest intestinal obstruction.

Discussion

Schilling's¹ excellent study cites only one case in 20 years at the University of Rochester, although during this period there were almost 200 cases hospitalized for perforated peptic ulcer. He enumerated 57

cases in the literature up till 1946. At a recent meeting in which our case was presented, two radiologists² volunteered that they had visualized fluoroscopically acute perforations once in their practice.

Our case is remarkable in that the patient recovered without operative interference despite the fact that he must have had a fairly large perforation in view of the rather marked amount of barium which is now visible in the peritoneal cavity. The patient was able to overcome the chemical peritonitis produced by the gastric juices and barium suspension. One might speculate whether these two components had an additive effect or whether one mitigated the effect of the other.

The irritant effect of barium is revealed by the operative findings in Schilling's case where two hours after the barium meal, the surgeon noted considerable fibrinous exudate agglutinating the extravasated barium. In dogs, Schilling found that sterile barium injected into the right upper quadrant caused severe reactions in the animals for several days. The dogs vomited frequently, refused food and drank but little. The animals, after about a week, made a satisfactory recovery and were sacrificed after a period of a few months for pathologic examination. The findings at autopsy demonstrated extensive adhesions wherever barium was present and enlargement of the lymph nodes with large amounts of barium contained within them. Microscopically, there was evidence of fibrosis, round cell infiltration and a marked phagocytic cell response with ingestion of barium particles. Some foreign body giant cells were also noted.

Although no mention is made as to the occurrence of subsequent intestinal obstruction of patients who have recovered, it would seem quite likely that such may eventually occur and that our patient has been rather fortunate up to this date.

Summary

A case is presented in which an unexpected finding in a routine G. I. Series was the presence of a large amount of intraperitoneal barium which had apparently leaked out during a perforated ulcer five years before. Although the condition gives rise to an extensive adhesive peritonitis, the patient has no symptoms referable to the intraperitoneal barium.

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Food and Drug Meeting

A one day Institute on the Food and Drug Law and related matters was held at Emory University May 7. Sponsored jointly by the School of Law and the School of Business Administration of Emory University the program was built around the Federal

Food and Drug Act as it relates to current economic and social questions. Some of the most distinguished men in the country, selected as the best in their field of operation spoke at this session.

NARCOTICS *and* CANCER

ENOCH CALLAWAY, M.D., LaGrange

The cancer patient presents a unique problem to the doctor who is called upon to decide when and what pain relieving drugs should be administered. Errors in judgement can result not only in unnecessary suffering or addiction to drugs but also can result in causing the patient to fail to obtain a cure of the disease when otherwise a cure could be obtained.

Since patients with cancer are always more or less mentally depressed and subject to periods of dependency, they are much more prone to develop dependency and habituation than are the usual surgical and medical patients. Since this is true, sedation and narcosis when needed as a temporary measure should, if possible, be accomplished by drugs having the minimal amount of habit forming qualities. Following surgery, if morphine or pantopon must be used, their use should be discontinued as soon as possible. Where narcotics must be continued for a considerable period of time, codeine or demerol may be satisfactorily substituted for morphine. This will make the discontinuance of narcosis much easier for both the patient and the doctor.

Discomfort and mild pain during the course of treatment are best handled with non-narcotic drugs, such as aspirin, acetanilide, and barbiturates, either separately or in combination. Larger doses of aspirin than are usually given when repeated at regular intervals will prove more effective than is usually believed. The desired effect is enhanced and unpleasant side effects diminished by having the patient take orange juice with the drug.

When the decision is finally made that the patient

is incurable, narcotics should not be given until absolutely necessary. Codeine in combination with other drugs should be used as long as it is effective. Starting with small doses, the amount should be increased judiciously and only after this has worn out should other drugs be used. Demerol frequently will fill the gap between codeine and morphine for a considerable period of time.

If the use of narcotics by these patients is not controlled, there will come a time when their effects are most needed, but due to previous abuse they will fail to give any relief.

Certain patients, particularly those with painful bone lesions, receive marked relief from cobra venom. This may be given in much higher dosages than has usually been recommended. Usually after one ampoule a day has been given for eight or 10 days, the effect can be maintained with two or three ampoules a week. Its use should not be abandoned until twice this dosage has been tried.

No one should prescribe narcotics for a cancer patient without consultation with the doctor who is actually treating the patient. Cured cancer patients have become addicts because their family doctor thought they were terminal cases. Others have been so lulled into a false sense of well-being by injudicious administration of narcotics that they have failed to continue treatment, thereby losing any chance for permanent cure.

By careful consideration of the patient's narcotic needs, not only can needless expense and unnecessary suffering be prevented, but also at times this consideration may mean life or death.

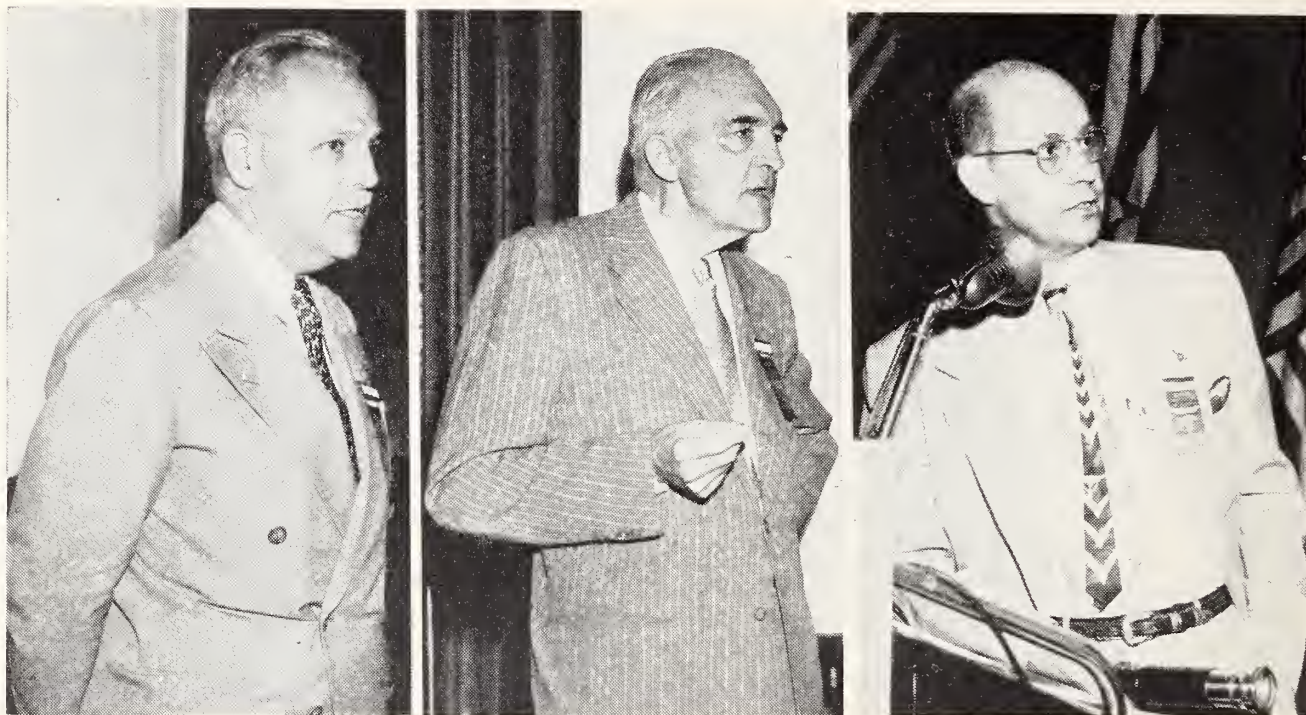
State Medical Education Board

At a recent ceremony members of the newly created State Medical Education Board were sworn in by Georgia Governor Herman Talmadge. From left to right: 1952-53 MAG President C. F. Holton, M.D., Savannah; W. F. Reavis, M.D., Waycross; Chappelle Matthews, Ga. House of Representatives, Athens; J. W. Mauldin, M.D., Alma; C. L. Howard, M.D., Pelham; J. Hubert Milford, M.D., Hartwell; and seated: Gov. Herman Talmadge.

At the Board's first session April 1, Dr. C. L. Howard was elected chairman and Dr. J. W. Mauldin elected vice-chairman. Phases of the operation of the new Board were discussed and organizational plans of operation set in motion.



From the 103rd Annual Session at Savannah



Candid photos of three of the many topflight speakers at Savannah Annual Session show the highlights of a very successful meeting. From left to right:

Alton Ochsner, M.D., New Orleans, La.; Heyworth N. Sanford, M.D., Chicago; and Robert D. Moreton, M.D., Fort Worth, Tex.

Report of

MEETINGS *of* COUNCIL

at 103rd Annual Session, May 10-13, Savannah

The Council of the Medical Association of Georgia met on Sunday, May 10, 9:00 a. m., Habersham Room, Hotel DeSoto, Savannah, with the following present: H. Dawson Allen (Chairman), David Henry Poer, C. F. Holton, George R. Dillinger, W. Bruce Schaefer, W. G. Elliott, William P. Harbin, Jr., H. L. Cheves, Clarence B. Palmer, John Turner, J. W. Chambers, Marion Pruitt, Sage Harper, Lee Howard, D. Lloyd Wood, and Mr. Sid Wrightsman, Jr.

The following action was taken:

1. *Approved*, as presented for referral to the House of Delegates, report of the Committee on Audit and Appropriations, including recommendation that Association annual dues be raised to \$25.00.
2. *Ordered* future investigation as to whereabouts of the Association History Fund, assumed to have been incorporated in former years in the general funds of the Association.
3. *Authorized* date revision of Association fiscal

year from January 1 through December 31 of any year.

4. *Approved* future deposit of accrued interest from the benevolent and building funds in the general funds.

The meeting adjourned at 9:45 a. m.

The Council met in breakfast session on Wednesday, May 13, 7:30 a. m., Habersham Room, Hotel DeSoto, Savannah, with the following present: H. Dawson Allen (Chairman), C. F. Holton, William P. Harbin, Jr., D. Lloyd Wood, George R. Dillinger, W. G. Elliott, Lee Howard, H. L. Cheves, Charles T. Brown, John Turner, W. Bruce Schaefer, Sage Harper, Clarence B. Palmer, J. W. Chambers, David Henry Poer and Messrs. Sid Wrightsman, Jr. and Milton Krueger.

The following action was taken:

1. *Authorized* J. W. Chambers to submit Association Employees Welfare Pension Plan to insurance authorities for impartial opinion.

2. *Referred* to 1953-54 Council aspects of Medical Defense Committee appointments.

The meeting adjourned at 9:05 a. m.

The new Council held its initial organizational meeting on Wednesday, May 13, 12:45 p. m., Grand Ball Room, Hotel DeSoto, Savannah, with the following present: David Henry Poer (presiding), William P. Harbin, Jr., H. L. Cheves, Ralph

W. Fowler, Neal F. Yeomans, Clarence B. Palmer, J. W. Chambers, W. Bruce Schaefer, D. Lloyd Wood, Lee Howard, George R. Dillinger, Mark S. Dougherty, Jr., W. G. Elliott, Peter B. Wright and Messrs. Sid Wrightsman, Jr. and Milton Krueger.

The following action was taken:

1. *Elected* H. L. Cheves as Council Chairman by acclamation.

2. *Approved* 1953-54 Association budget as presented by Audit and Appropriations Committee.

3. *Authorized* \$200.00 travel expense for each AMA Delegate (Richardson and Allen) in attendance at the June AMA Annual Session in New York City.

4. *Authorized* travel expense for the executive secretary to attend June AMA Annual Session in New York City.

5. *Authorized* establishment of special committees at the discretion of President Harbin.

6. *Designated* Marion Pruitt as Medical Defense Committee Chairman, with Association Legal Advisor John Dunaway as Committee liaison officer.

7. *Designated* George R. Dillinger and Mark S. Dougherty, Jr. as Council members to comprise the Council Executive Committee (in addition to President and Secretary).

8. *Authorized* President-Elect Wright's attendance (without vote) at future Council meetings.

9. *Scheduled* next Council meeting on Sunday, June 14, 11:00 a. m., Academy of Medicine, Atlanta.

10. *Accepted* special invitation extended by Lee Howard for Council to meet at Savannah on Sunday, October 18.

The meeting adjourned at 1:10 p. m.

Better Health Council

When the late Steve Kenyon, M.D., president of the Medical Association of Georgia, suggested the need for a coordinated health program in Georgia, little did he realize that the plans made at a meeting of 100 citizens at The Academy of Medicine in Atlanta in March, 1948, would grow into a permanent *Better Health Council*. Today, thousands of lay people throughout the State are being inspired to improve local health services through the media of Regional Health Conferences and community Health Councils.

During the past five years the Better Health Council program has been guided by a Board which has always included the president of the Medical Association of Georgia with members of the Medical Association of Georgia and representatives of other

health agencies. Serving on the present Executive Board of the Council are the following MAG members: Tully Blalock, M.D., Enoch Callaway, M.D., William F. Friedewald, M.D., C. F. Holton, M.D., G. Lombard Kelly, M.D., A. Park McGinty, M.D., Christopher McLoughlin, M.D., Sam E. Patton, M.D., T. F. Sellers, M.D., R. Hugh Wood, M.D.

Included in current plans for expanding the Better Health Council program are a series of radio recordings participated in by member health agencies; the publication of the first Directory of health agencies in Georgia; and a quarterly News Sheet which will disseminate information from the member health agencies and will be sent to community leaders in each County of the state.

ANNOUNCEMENTS

JUNE 22-JULY 31: A Day Camp for physically handicapped boys and girls, sponsored by the Cerebral Palsy School-Clinic of Atlanta, Inc. as an extended service for the handicapped of Atlanta and neighboring communities will be in session from June 22 through July 31, 1953.

Registered occupational and physical therapists, under medical direction, will supervise a program of therapeutic recreation, handicrafts and group socialization. Activities will be adapted to individual needs and interests. Applicants will be screened by our medical board and campers will be selected on the basis of the benefit the child can derive from our facilities.

Further information and application blanks may be secured from The Cerebral Palsy School-Clinic of

Atlanta, Inc., 1815 Ponce de Leon Avenue, N. E., Atlanta, Georgia.

JULY 20: The Southern Pediatric Seminar will hold its 33rd annual session this summer in Saluda, North Carolina. Two weeks (July 20 through August 1) will be devoted to pediatrics and one week (Aug. 3 through 8) will be devoted to obstetrics.

The course consists of lectures, clinics, demonstrations, clinical pathological conferences. The members of the faculty are equally divided between physicians in teaching positions and physicians in active practice. Ample opportunity is given for discussions in small groups and for the answering of questions. Every effort is made to give the general practitioner the material and information which he needs in his every day practice. The course is fully accredited by the American Academy of General Practice.

Any general practitioner who is anxious to catch up on what is new in the field of pediatrics or obstetrics is urged to write for further information to Dr. D. L. Smith, Registrar, Saluda, North Carolina.

SOCIETIES

Second District Medical Society held its semi-annual meeting in Albany on April 2 and the following officers were elected: President, Dr. Phil E. Roberson, Albany; Vice-President, Dr. John F. McCoy, Moultrie; and Secretary-Treasurer, Dr. Frank A. Little, Thomasville.

The next meeting is slated for October 1, 1953 in Moultrie.

Third District Medical Society met on April 23 at the Veterans State Park, Lake Blackshear between Americus and Cordele. The scientific session included papers by Dr. M. B. Hatcher, Macon—"Surgical Lesions of the Colon;" Dr. W. L. Barton, Macon—"Sphenoidal Sinusitis;" Dr. Donald Bickers, Atlanta—"The Differential Diagnosis and Management of Epilepsies;" Dr. Bruce Logue, Atlanta—"Pitfalls in the Diagnosis of Heart Disease;" and Dr. Lidelle Chandler, Augusta—"Forearm Fractures." New officers will be named at a fall meeting.

Sixth District Medical Society held their summer meeting in Dublin on April 29. As a feature of the scientific session, a Cancer Symposium was held. Dr. Enoch Callaway, LaGrange was the guest discussor and Dr. Hoke Wammock, Augusta was the moderator. Participating on the panel were Dr. Thomas Harrold, Dr. Max Mass, Dr. R. M. Reifler, Dr. J. P. Woodhall and Dr. C. H. Richardson. The Veterans Hospital staff presented illustrative cases on the subject "The Diagnosis and Treatment of Carcinoma Occurring in Various Sites."

The meeting was followed by a dinner for members and their wives at the Dublin Country Club.

Seventh District Medical Society met at the Coosa Country Club, Rome, on April 1. New officers elect-

ed are as follows: President—H. L. Erwin, Dalton; President-Elect—W. D. Hall, Calhoun; and Secretary—R. N. Johnson, Rome. Nominated for Councilor and Vice-Councilor respectively were: D. Lloyd Wood, Dalton and Ralph W. Fowler, Marietta.

Scientific papers were presented by Dr. Lee H. Battle, Jr., Rome, "Intraperitoneal Rupture of a Hydronephrosis, Report of a Case;" Dr. Emmett S. Brannon, Rome, "Disturbances of Cardiac Rhythm;" and Dr. Stephen D. Smith, Rome, "Erythroblastosis Fetalis."

Dr. C. F. Holton, MAG President, delivered an address and the meeting was followed by a barbecue dinner.

Eighth District Medical Society held their semi-annual meeting at Valdosta on April 14. The following members were named to serve on MAG Committees: Councilor, Neal F. Yoemans, Waycross; Vice-Councilor, J. M. Hicks, Brunswick; Rural Health, L. H. Shellhouse, Willacoochee; Legislative, F. G. Eldridge, Valdosta; Public Health, J. Gregg Smith, Valdosta; and Public Relations, Harry Mixson, Valdosta.

Scientific papers were presented by Dr. Van B. Bennett, Valdosta, "Medical Management of Patients Requiring Surgery;" Dr. Edward K. Russell, Atlanta, "Congenital Heart Disease, Practical Points and Office Diagnosis of Those Patients Amenable to Surgical Treatment;" and Dr. Robert E. Perry, Jr., "Presentation of Suspected Case of Hansen's Disease."

Short addresses were also given by the MAG President, President-Elect and Secretary. A social hour and dinner closed the meeting. Next meeting will be October 13 in Waycross.

Ninth District Medical Society met for their spring session at the North Georgia Trade School, Clarkesville, on April 15.

At the scientific session, papers were presented by Dr. George T. Nicholson, Cornelia, "Gangrenous Pneumatocele of the Greater Omentum;" Dr. Charles M. Henry, Clarkesville, "Cancer of the Colon, Onset of Symptoms Due to Inflammation;" and Dr. J. L. Walker, Clarkesville, "Congenital Common Bile Duct Obstruction, Report of Two Cases in One Family."

DEATHS

FUTCH: *Dr. Thomas Allen Futch, Jr.*, 44, of Thomasville, died in his home March 20. Dr. Futch had been seriously ill for some time and had been bravely continuing his practice despite his illness. (In a MAG communication from Dr. Henry Moore, also of Thomasville, Dr. Moore expresses the local sentiment as follows: "Dr. Futch leaves many, many grateful patients who are living monuments to his work, time, care and efforts.")

Dr. Futch was a graduate of Medical College of Georgia, 1935. A native of Thomasville, Dr. Futch had been active in the practice of medicine in Thomasville since his graduation from medical school.

EAVES: *Dr. B. F. Eaves*, 83, of Draketown, died in a private hospital in Villa Rica, April 1, after an illness of several months. Born in Haralson

County, Dr. Eaves had been a practicing physician for the past 60 years. He was a graduate of Emory University School of Medicine, 1893.

Dr. William Harbin, MAG President-Elect and Mr. Sid Wrightsman, Jr., MAG Executive Secretary also addressed the meeting.

Elected at this session were the following officers: President, E. L. Ward, Gainesville; Vice-President, Alex Russell, Winder; and Secretary, George Nicholson, Cornelia.

The meeting closed with a social hour and dinner.

IRVIN: *Dr. I. W. Irvin*, 61, of Albany, died April 25 in the Phoebe Putney Hospital. He had practiced in Albany for the last 32 years and previously was associated with Dr. Phinizy Calhoun of Atlanta. A graduate of Atlanta Medical College in 1914, Dr. Irvin interned at Grady Memorial Hospital, Atlanta and specialized in EENT.

SMITH: *Dr. D. D. Smith*, 87, of Swainsboro, died March 15 at Emory University Hospital where he had been ill for two months. A native of Emanuel County, Dr. Smith had lived in Swainsboro all his life. He was county physician for about 20 years and city physician for 10 years. Dr. Smith owned a private hospital in Swainsboro where he had practiced medicine for more than 40 years. He was a graduate of the Medical College of Georgia, 1908.

Dr. L. P. Holmes, Radiology; *Dr. E. V. Hastings*, Pathology, and *Dr. Perry Volpitta*, Anesthesiology.

Dr. William R. Chambers, of Atlanta, is now associated with The Neuroclinic in the practice of neurological surgery.

Dr. W. F. Hamilton, *Dr. Philip Dow*, *Dr. John Remington*, and *Dr. Elna Lombard* of the department of Physiology, Medical College of Georgia, Augusta, attended the annual meeting of the American Physiological Society in Chicago, April 7 to 9. Dr. Remington delivered a paper on the action of the heart muscle as affected by various drugs; Dr. Lombard presented an analysis of the normal electrocardiogram of the dog; Dr. Dow discussed the mathematical analysis of the concentration curve of dye injected into the circulation of animals and of man.

In addition to the meeting of the Physiological Society in Chicago, Dr. Hamilton also attended the annual meeting of the American Heart Association in Atlantic City where he gave the Conner Memorial Lecture before the Heart Association on the topic, "The Physiology of the Cardiac Output."

Lt. Col. Daniel W. Calvin, formerly of North Hollywood, California, relieved *Lt. Col. J. C. Vanmeter* as Base Surgeon at Robins Air Force Base.

Dr. Amey Chappell, of Atlanta, addressed the

PERSONALS

Dr. M. C. Adair, of Washington, has had work started on his new office building on South Spring Street in Washington. The construction work will probably be completed within the next six weeks. *Dr. A. D. Duggan*, also of Washington is also planning to erect a new building and construction will start at an early date.

Dr. Tully T. Blalock, of Atlanta was recently named among the 100 Atlantians picked as the future leaders of the city. He was chosen from a field of 1,100 candidates nominated for this honor.

Dr. and Mrs. J. M. Byne, Jr., of Waynesboro, sailed on the Queen Mary April 15 for a two month tour of Europe. The Bynes will return sometime early in June.

Dr. W. W. Battey, of Augusta, was named president of the staff of St. Joseph's Hospital, Augusta. *Dr. Stephen W. Brown* was named president-elect and *Dr. J. B. Bowen* as secretary-treasurer. The following department heads were also named: *Dr. J. D. Gray*, Medical; *Dr. Thomas W. Goodwin*, Surgical; *Dr. J. William Thurmond*, Obstetrics and Gynecology; *Dr. Thomas E. Bailey*, Pediatrics; *Dr. J. Viotor Roule*, EENT; *Dr. F. X. Mulherin*, General Practice;

Fulton County Medical Society Auxiliary May 1 on the subject "Obstetrics in Africa."

Dr. Charles E. Dowman, of Atlanta, presented a lecture on "Neurological Aspects of Back Pain" at the Forest Hills division of the Veterans Administration Hospital on April 10.

Dr. John D. Elder, of Athens, spoke to the Athens Business Girls Club March 24, on the subject of "Socialized Medicine." At the conclusion of his talk, Dr. Elder explained organization of the local medical societies.

Dr. John W. Good, of Cedartown, was recently honored in a biographical writeup which appeared in the Sunday magazine section of the *Atlanta Journal and Constitution*. Dr. Good has recently been chosen by Georgia Governor Herman Talmadge to represent Georgia at the first Western Hemisphere Conference of the World Medical Association.

Dr. I. S. Giddens, of Lakeland, recently gave radio addresses on station WGOV on the Racial, Sex and Age Distribution of Tuberculosis.

Dr. William Hall Holden, physician-explorer of Macon, recently showed films of his tour of the jungles of the Amazon in South America at a meeting of the Macon Secretaries Club.

Dr. William G. Hamm, of Atlanta attended the recent Western Hemisphere Conference of the World Medical Association in Richmond, Va. Dr. Hamm took part in a panel discussion and will contribute a chapter to a commemorative volume entitled "Seventy-Five Years of Medical Progress."

Dr. Harvey Hamff and *Dr. Walter Bloom*, both of Atlanta, addressed the Diabetes Association of Atlanta at a recent meeting at the Academy of Medicine in Atlanta.

Dr. J. Willis Hurst, 32-year-old heart specialist at Emory University Hospital, Atlanta, was honored by being listed among the 100 young men selected from a field of over 1,000 for "Leaders of Tomorrow." The selections were sponsored by *Time* magazine and the Atlanta Chamber of Commerce.

Dr. Stewart M. Long, of Atlanta, announces the reopening of his offices for the practice of surgery at 33 Ponce de Leon Avenue, N. E., Atlanta.

Dr. C. F. Holton, Savannah, attended the annual meeting of the Medical and Surgical Section and Chief Surgeons of the American Association of Railroads in Chicago, April 5-9. The 1954 session of this organization will be held in Savannah during March.

Dr. Harold P. McDonald, of Atlanta, delivered a paper on "Urinary Tract Infection" at the Annual Meeting of the South Carolina Medical Association May 6.

Dr. W. C. McGeary, Morgan County physician, was again honored by the Athens Lodge No. 790, Elks, recently when he was elected as trustee of the

lodge. This is the first time in the history of the lodge that a member outside of Athens has been elected to the trusteeship.

Cairo Kiwanians recently devoted a luncheon program to honoring five of Grady County's older doctors. The doctors accorded this recognition were *Dr. Council H. Maxwell*, Calvary; *Dr. T. J. Arline*, Cairo; *Dr. M. W. Dykes*, Whigham; *Dr. W. A. Walker*, Cairo; and *Dr. J. B. Warnell*, Cairo.

Dr. Rufus Payne, of Augusta, presented a paper on "Control Study of Isonazid, a Public Health Service Cooperative Investigation" at the 19th Annual Meeting of the American College of Chest Physicians in New York, May 31.

Dr. Jean J. Paschal, of Albany, has been certified as a diplomate of the American Board of Pediatrics.

Dr. John H. Ridley, of Atlanta, announces the removal of his office from Suite 1111, Medical Arts Building to Suite 110, Medical Arts Building, Atlanta.

Dr. Harry Evan Rollings, of Savannah, has reentered the practice of internal medicine at his previous location, 120 East Gaston Street, Savannah, after a 21 month tour of duty with the Air Force as Chief of Medical Service at Hunter Air Force Base and overseas assignment.

Lt. Comdr. W. A. Risteen, of Augusta, who has been on duty with the U. S. Navy for the past two years, is back in Augusta and will resume his work as a member of the faculty of the Medical College of Georgia. While on Navy duty, Dr. Risteen served on the hospital ship *Repose*, which has been at sea off the shores of Korea.

Dr. and Mrs. Robert J. Rinker, of Augusta, recently spent a week in Havana, Cuba, where Dr. Rinker attended the meeting of the Southeastern section of the American Urological Association. Dr. Rinker participated in the program, presenting a film on a surgical operation for tuberculosis epididymis.

Dr. James Wendell Rhea, Jr., of Columbus, was recently engaged to Miss Elizabeth Ann Boon, of Atlanta. The marriage will take place June 6, in the First Presbyterian Church of Atlanta.

Dr. V. P. Sydenstricker, of Augusta, was recently honored by an award by the staff of *The Cadaver*, Medical College of Georgia school newspaper. The citation was for excellence in teaching at the Medical College of Georgia. An annual award, a silver cup was presented Dr. Sydenstricker.

Dr. Richard L. Schley, Jr., of Savannah, spoke on "Health in the Community" at a meeting of the Moore Avenue P.T.A.

Dr. J. B. Stewart, of Macon, recently addressed the Macon Y-Civic Club at a meeting held in the Macon YWCA Building. His topic was "Socialized Medicine."

Dr. Edmund Virusky, former chief of surgery at the Leaphart Hospital in Jesup, has opened his office

in Baxley and his office will be in the former Hugh Rogers home.

HOSPITALS

A new modern medical unit in the Children's home of Chatham County, a project of the Woman's Auxiliary of the Georgia Medical Society was recently dedicated. Keys were turned over to Mrs. John G. Sharpley, president of the Juvenile Protective Association Board, by Mrs. W. Loyd Osteen, president of the medical auxiliary. The project, initiated by Mrs. C. R. A. Redmond and completed under the supervision of Mrs. John W. Daniel, Jr., chairman of the medical auxiliary project committee.

The medical unit consists of a medical examining room, medical isolation room, bath and toilet, all of which are adequately equipped.

Open house was recently held at the opening of a new clinic in Blackshear which will be occupied by Dr. Thomas C. Nation and Dr. Richard A. Dodelin, both graduates of Emory University School of Medicine.

The trustees of Piedmont Hospital, Atlanta, have announced a drive for funds to construct a new hospital on Peachtree Road. Piedmont Hospital is a nonprofit institution operated by a board of trustees and laymen. This new plant will help meet the need of a growing Atlanta with an estimated 238 beds. It will cost around three and one-half million dollars and the public will be asked to contribute one and one-half million dollars. Members of the medical staff opened the drive with gifts averaging more than 4,000 dollars each.



Medical College of Georgia Group Visiting the Lilly Research Laboratories, Indianapolis, Ind., Mar. 11-13, 1953

First Row: Nino Hort, Julio Morie Heng, Clarence Weaver Rowson, Jr., Mrs. William E. Barfield, Dr. William E. Borfield, Mrs. William Fred Lindsey, William Fred Lindsey, Lois Strickland, Agotho Moody.

Second row: Joseph Kotz, Mrs. Joseph Kotz, Robert Lane Peorce, Mrs. Robert Lane Peorce, Edmund Mork Nicholas, Mrs. Edmund Mork Nicholas, Mrs. Frank Dempsey Guillebeou, Frank Dempsey Guillebeou, Hugh Lumpkin Coffee, Mrs. Hugh Lumpkin Coffee.

Third row: Martin Alperin, James Frederick Adams, Jr., Henry Deering Scoggins, Donald Carl Chait, Haskell Milton Heller, Mrs. John Nelson Bickers, John Nelson Bickers, Gordon Ervin Walters, VonBibb Soye, Jr., John Munn Heng.

Fourth Row: John Groy Modry, Jr., Frank Alfonso Rizzo, Harold Smith Ramos, Calvin Lossetter Throsh, Jr., Hermon Peskin.

MANIC-DEPRESSIVE PSYCHOSIS

The incidence of manic-depressive psychosis is definitely increasing and in many sections of this country its frequency surpasses that of the schizophrenic group. There appears to be a familial basis for the development of this mental disorder in many cases, though the manner of transmission is not understood. Kraepelin, a German psychiatrist, found that a large percentage of persons who developed manic-depressive psychosis had some form of the "up and down" personality. In the majority of patients one is able to discover depressive and cyclothymic pre-psychotic make-ups. Investigations have led to the recognition of the predisposition to manic-depressive psychosis in the so-called "pyknic" habitus. The "pyknic" is relatively short in stature, has a rounded, stocky, muscular build, broad face, and large head and chest. From the standpoint of personality the manic-depressive is, in his pre-psychotic make-up, an extrovert. Extroverts are sociable, energetic, bright and cheerful, with a strong tendency to go into action. They are not reflective and their intense emotional reactions are not sustained. When some unknown factor, which may be contained in the inheritance or in psychopathology produced by the conditions of life, is added to the extroverted temperament, the result is likely to be a manic-depressive psychosis. In the manic-depressive group, there is a definite exaggeration of the extroverted qualities; labile emotions, vivacity, a dynamic push of energy, distractable thinking, and an easy rationalization of mistakes.

Often, the phase of mania seems to be the acting out of a compensation for bodily inferiority. Thus, a weak, undersized, awkward, un-athletic and physically inferior individual may occupy himself during the recurrent manic phases of his psychosis with the boastful performance of what he considers to be great feats of strength and agility. Manic-depressive psychosis is a type of extroversion reaction. That is, the patients, instead of turning within themselves (introversion) try to escape from their conflicts by a "flight into reality". This flight into reality is the manic phase of the psychosis with its flight of ideas, distractability, and increased psychomotor activity. During this stage the patient seems to be almost at the mercy of his environment; his attention is diverted by every passing stimulus. The great activity is a defense mechanism. The patient, by his constant activity, covers every possible avenue of approach

which might touch upon his complexes and so rushes wildly from one possible source of danger to another, keeping up a stream of diverting activities. A study of manic productions sometimes discloses that they refer to, or re-animate, longed for situations of the past, the memories of which have been repressed. In a way the manic reaction is an ambivalent one. Under the cloak of hyperactivity and flight of ideas there develops a wish-fulfilling drama in which the forbidden or unattainable fantasies come to expression. The psychosis is not characterized so much by the nature of the conflict with which the patient has to deal but by the way in which he deals with it. The failure to actually deal adequately with the difficulty is manifested by the depression of the depressive phase. In depression the defenses have broken down and the patient is overwhelmed by self-accusatory thoughts. There are several factors that caution us not to overrate the importance of the psychogenic factors in manic-depressive psychosis. A strict periodicity characterizes the alteration of mood in many cases; this periodicity appears to be independent of any external event and indicates the operation of a biological factor.

Hypomania, the initial phase of the manic state, is manifested by a push of speech and motor activity. The productions are usually coherent and relevant but greatly increased in quantity, and facetious. Patients are usually boastful, optimistic, and aggressive. Attempts to curb their enthusiasm or hinder their expansive plans bring outbursts of irritability. Many of these patients get along outside of an institution but are a source of annoyance to their families and fellow workers. A few successfully launch business enterprises, charitable organizations, or sell large quantities of goods during the early stage of their hypomanic reactions. Some of these patients subside into a chronic, irritable state with frequent complaints directed toward the environment. This is because of refusal of others to cooperate in their schemes and recognize their "true worth". Many develop paranoid tendencies because of the failure of others to accept them at their own evaluation. Still others develop chronic, diffuse, frequently shifting, hypochondriacal complaints. This hypomanic stage frequently ushers in an acute manic episode.

Individuals in the stage of acute mania require

hospitalization as a protection to themselves and the community. They are overactive, combative, obscene, profane, and destructive. If allowed to be at large in the community they often indulge in alcoholic and sexual excesses; they often make unwise investments and large purchases of useless objects. Feeding becomes a serious problem because they are too busy to eat. Tube feeding may be necessary to combat starvation and dehydration. Sleep is interfered with by the hyperactivity. Sedative drugs in large doses are usually ineffective. The stream of thought is definitely accelerated, with an almost continuous stream of conversation. Patients are distractable, and complain of a crowding of ideas and a pressure of thought. The progression of thought shows rapid shifts from one topic to another. These shifts are in terms of events in their environment distracting them from their original theme. The mood is one of definite elation. When thwarted they respond with sudden and spectacular outbursts of rage. Hallucinations and firmly held delusions are uncommon; when they occur they are usually of an expansive wish-fulfilling type. The patient's grasp of general information and his memory are well preserved but examination of these systems is difficult because of the distractability. Insight is often present to a considerable degree. In many instances they state flatly that they are "a manic".

The manic episodes tend to occur in periodic attacks. Their frequency varies greatly, some patients having only one or two attacks in a life-time while others may average one a year. Careful supervision and psychotherapy during the interval between attacks can do a great deal to eliminate or lessen the frequency of attacks. Attacks usually last from several months to eighteen months, unless terminated by electric shock therapy. Treatment with electric shock therapy usually results in remission within a period of several weeks. The remission rate is estimated to be eighty percent, with this form of treatment.

The depressed phase of manic-depressive psychosis is referred to as an autonomous depression, that is, a depression arising within the individual. The severity of the symptoms vary from simple retarda-

tion to acute depression and stupor. In the state of simple retardation patients complain of being slowed up in thought and action. The mood is expressed as depressed, sad, or blue. Patients feel dejected, defeated, or exhausted. They tend to blame themselves but feel that there is no true explanation for the way they feel. The sensorium is clear.

In the stage of acute depression there are marked changes in behavior. Patients neglect their persons and present a dejected, disheveled appearance. They take little interest in environmental happenings, although they seem acutely aware of what is going on about them. They may stand or sit in slumped or limp positions for long periods. Others show motor agitation with restless pacing about, wringing of the hands, and picking at themselves; in some cases this is carried to the point of self-mutilation. Suicide is an ever-present danger. Patients often make desperate attempts to commit suicide and seem to purposefully select painful and messy methods of suicide such as extensive self-mutilation, jumping from moving vehicles, and jumping out of buildings, or setting fire to themselves. The stream of mental activity is markedly slowed and they complain of difficulty in thinking. Spontaneous productions are colored by the depression and are markedly decreased in quantity. There is a fixed mood of depression and hopelessness. Frequently there is refusal of food, necessitating tube feeding. Sleep is disturbed, the patients tending to awaken after a few hours of sleep, constipation is an ever-present problem. Sex drive is absent in men, and in women there is often cessation of menstruation. Patients frequently express feelings of guilt. They blame themselves for their troubles and feel that they are to blame for the troubles of the world. They often express ideas of having committed unpardonable sins. They may fix upon some minor deviation from morality of many years ago. Delusions of incurable diseases are common. Patients often believe that various parts of their body are dead or have decayed or disappeared. Insight, which may be good during the initial phase of the illness, disappears, and the patient is "certain" of his degradation and helpless predicament.

HARRY R. LIPTON, M.D.

This is one in a series of articles published by

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Advertisement



From where I sit by Joe Marsh

Chip Pulls a "Pip"

Chip Hanson is a clever commercial artist. Besides doing cartoons on our paper, he picks up "free lance" drawing jobs.

Right now he's whipping up some posters for the Safety Campaign. They all have headlines like "PLAY IT SAFE!" . . . or, "A LIVE WIRE CAN START A FIRE!"

Chip looked a bit sheepish yesterday. Didn't want to tell me why. Finally he blurted out, "I feel like a dope. Here I am on this safety program and the fire inspectors tell me *my own studio's a fire trap*. I've been storing paint there for years . . ."

From where I sit, what happened to Chip could happen to anyone. He was just too busy informing everyone else about safety—not realizing his safety was threatened. Like those who fret about their neighbors—how they should practice their profession, whether they should have coffee or a glass of beer with lunch—Chip simply forgot to "draw" some obvious conclusions about himself!

Joe Marsh

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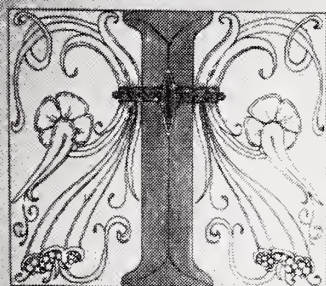
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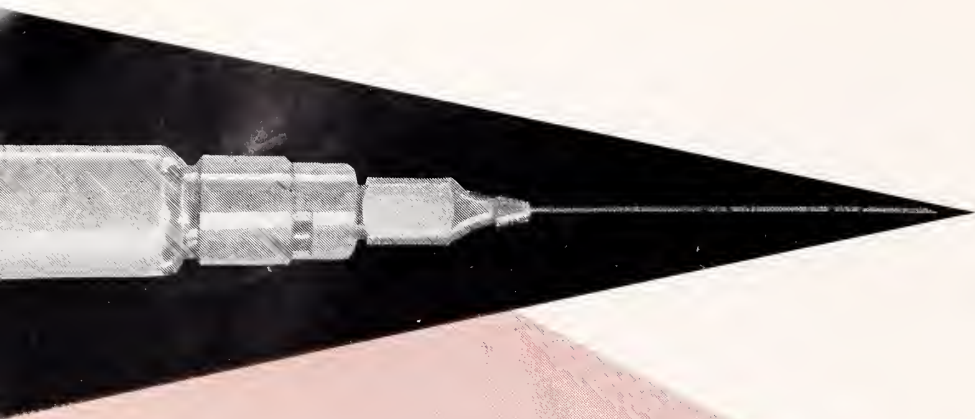


I SWEAR by Apollo, the physician, by Aesculapius, by Hygieia, by Panacea, and by all the gods and goddesses, calling them witness that according to my ability and judgment I will in every particular keep this, my oath and covenant: To regard him who teaches this art equally with my parents, to share substance, and, if he be in need, to relieve his necessities; to regard his offspring equally with my brethren; and teach them, if they shall wish to learn it, without fee or stipend; to impart a knowledge by precept, by lecture, and by every mode of instruction to my sons, to the sons of my brethren, and to pupils who are bound by stipend according to the law of medicine, but to

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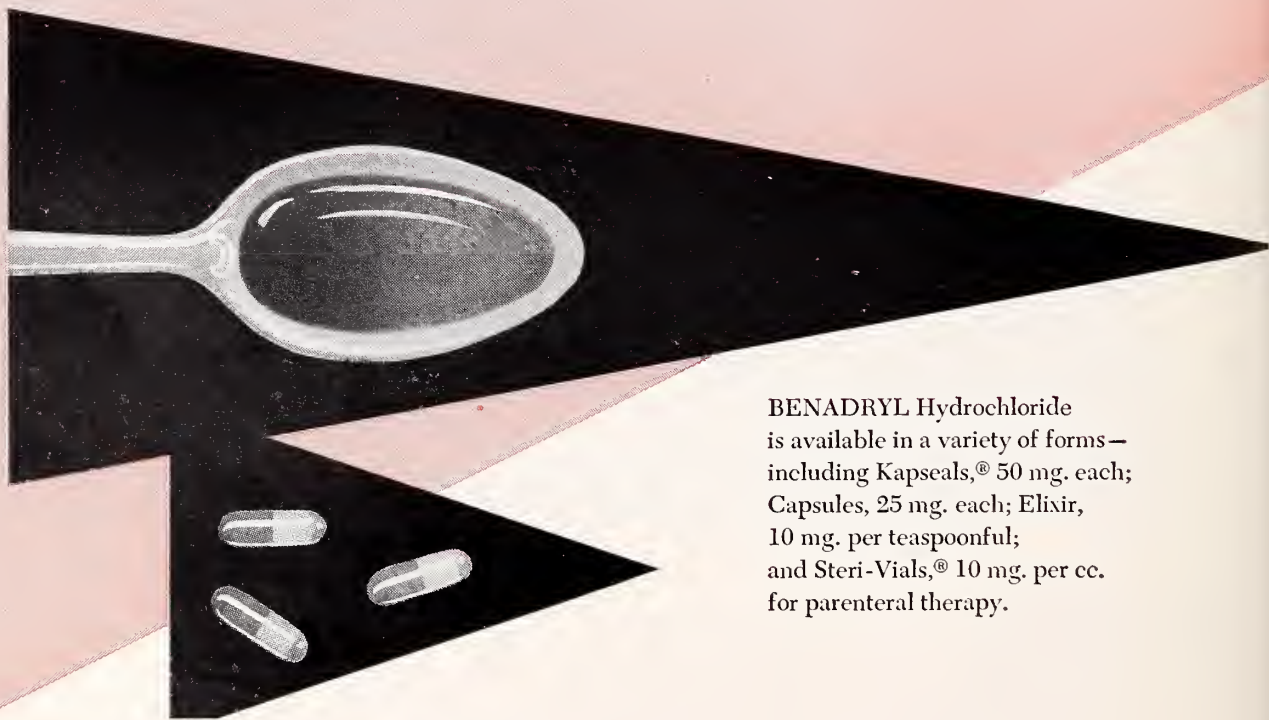
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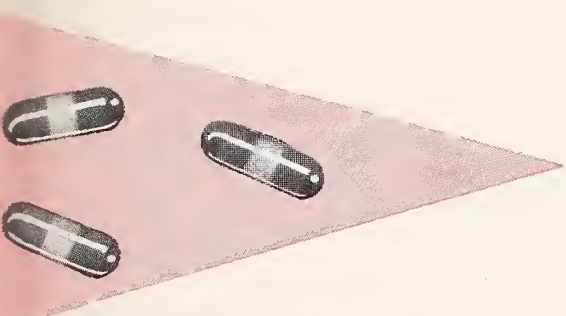


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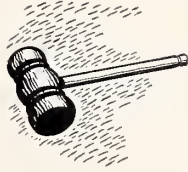
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President's Page

One of the more important phases of your association's activities is a comprehensive Public Relations Program. The necessity for such organizational performance was discussed by Secretary Hobby in her address to the House of Delegates of the American Medical Association at its recent meeting in New York. She expressed confidence that our profession will solve the social and economic problems that face us. But in the event we fail, it is her belief that the solution will be taken out of our hands.

We should continue to encourage a warm and friendly relationship with the press, radio and television, which has already been initiated. Because of the fact that those who believe in socialization have made an effort to discredit the achievements of American medicine, we must remind the public that they receive the best medical care in the world, and this has been largely responsible for the good health they enjoy today. Their attention should be called to the willingness of the doctors to assume the care of the indigent, making a service donation probably not equalled by any other professional group. Families should be encouraged to select and become well acquainted with a family physician before an emergency arises. More individuals should be asked to participate in prepayment plans for hospital and medical care, and to assume the common responsibilities which are necessary for advances in the health of our nation.

Publicity should be directed toward convincing the public that our profession is intensely interested in its health needs, and this should be followed by action to prove our sincerity. The latter should include an individual doctor-patient public relations program in everyday practice, 24-hour emergency call systems, and provision for the care of the indigent, in those communities where such services do not exist. A hospital tissue committee is the medium through which unnecessary surgery can be avoided. The formation and use of professional conduct or mediation committees should be a part of the function of more county societies.

Enough emphasis cannot be placed on the necessity for doctors to be reasonable in their charges to patients. It is the duty of your county society and your state association to change the attitude of the relative few in our midst who persist in discrediting the healing arts by placing financial considerations above the welfare of the patient.

WILLIAM HARBIN

The JOURNAL of the Medical Association of Georgia

PLAN NOW FOR YOUR 1954 ANNUAL SESSION IN MACON MAY 2 - 5, 1954

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New Drugs



New Drugs in the Treatment of Epilepsy

Ever since the important finding by Merritt and Putnam that anticonvulsants need not exhibit the sedative properties of bromides and phenobarbital, the treatment of epilepsy has taken many great strides. The clinician has continued to be disturbed by the fact that he can hope to achieve control of only a limited percentage of cases with any one drug, and that signs of chronic toxicity often necessitate withdrawal of an otherwise successful agent. Pharmacologists have continued their efforts to find further effective agents to include in the armamentarium of the physician. The clinician, on the other hand, has done considerable research into the effects of combinations of known agents, with an eye to reducing the toxicity encountered while maintaining equi-effectiveness.

During recent years, the search for new compounds has been helped tremendously by the establishment of screening techniques which have some small qualitative correlation with clinical effectiveness. The most useful of these is a test in which the new compound is examined for its effectiveness against a maximal electroshock convulsion in rats or mice. This convulsion is not unlike the electroshock convulsion used in humans in psychiatry. Another testing procedure is the protection of mice from the convulsant and lethal effects of intravenously administered pentylenetetrazole (Metrazol). A modification of the electroshock used in the first test yields a partial seizure in mice which is not unlike the picture in psychomotor attacks. Critical examination has again shown, however, that there is too little correlation between clinical effectiveness in psychomotor seizures and experimental results. There is very little doubt that well-trained, cautious investigators can use the above experimental procedures to great advantage in the search for new anti-epileptic drugs. It has been repeatedly emphasized, however, that the ultimate usefulness of an antiepileptic agent must be determined by clinical experience. During preliminary clinical examination, the new drug is under the disadvantage of being used in those cases where an older, proven compound was previously shown to be ineffective; if it is to be substituted for an older compound which was only partially effective, one must expect

initial exacerbation of seizure frequency and severity before control is achieved. This test of clinical efficacy does not belong in the office of the practitioner, but must be made under carefully controlled conditions in institutions or clinics.

Many new compounds are presently appearing on the market to be used in the treatment of epilepsy. Unfortunately, there is only space to briefly discuss two which may ultimately find a real place as new, potent anti-epileptic drugs:

1. N-benzyl-beta-chloropropionamide (Hibicon) is a new anticonvulsant with high efficacy which has been reported to have only few side reactions and to have a wide margin of safety. Experimentally, it is quite similar to Dilantin in its action. It is somewhat more potent than Dilantin in the metrazol test. It is not a sedative or an analgesic. It appears to have no major actions other than those on the central nervous system. Large doses seem to induce emesis, but chronic administration of effective anticonvulsant doses does not. Clinically, it has found application in the treatment of grand mal and psychomotor seizures. First reports emphasize the lack of unpleasant side effects. This drug is new and its place in therapy cannot be completely evaluated as yet due to its limited application.

2. Phenacemide (Phenurone) is an agent which has been shown to have a wide spectrum of experimental and clinical anticonvulsant activity. Its most notable action is in clinical psychomotor epilepsy. However, it suffers from the disadvantage of dangerous toxicity. Toxic symptoms include personality changes, hepatic damage and bone marrow depression. This drug should only be used by physicians experienced in the treatment of epilepsy in cases where other drugs have been shown to be ineffective. Its use should be accomplished by careful laboratory control of the blood and of liver function. The fact this compound, after having shown such severe toxicity, was included in New and Non-Official Remedies testifies to its great effectiveness in refractory epilepsy of the psychomotor, grand mal, petit mal and mixed seizure types.

PETER E. DRESEL, PH.D.

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The Bookshelf

BOOKS RECEIVED

TRANSLATIONS OF THE AMERICAN COLLEGE OF CARDIOLOGY: Vol. II, 1952. Editor, Bruno Kisch, M.D. Published by American College of Cardiology, 140 West 57th Street, New York 19, N. Y. Price \$5.00.

AN INVENTORY OF SOCIAL AND ECONOMIC RESEARCH IN HEALTH (1953 Edition): Compiled by Frederick R. Strunk. 180 pages. Published by Health Information Foundation, 420 Lexington Avenue, New York 17, N. Y.

THE PHYSICAL EXAMINATION OF THE SURGICAL PATIENT: By J. Englebert Dunphy, M.D., F.A.C.S., Associate Clinical Professor of Surgery, Harvard Medical School; and Thomas W. Botsford, M.D., F.A.C.S., Clinical Associate in Surgery, Harvard Medical School. 326 pages with 188 figures. Philadelphia and London: W. B. Saunders Co. Price \$7.50.

DRUG ADDICTION AMONG ADOLESCENTS: Conferences held at The New York Academy of Medicine on November 30, 1951 and March 13 and 14, 1952, sponsored by the Committee on Public Health Relations of The New York Academy of Medicine with the assistance of The Josiah Macy, Jr., Foundation. 320 pages. The Blakiston Company, New York and Toronto. Price \$4.00.

THE PHYSICIAN IN ATOMIC DEFENSE: Thad P. Sears, M.D., F.A.C.P., Associate Clinical Professor of Medicine, University of Colorado School of Medicine; Chief of Medical Service, Veterans Administration Hospital, Denver; Member of Advisory

Staff to Director of Civil Defense, State of Colorado; Member of Disaster Commission, Colorado State Medical Society; Colonel (M.C.), U.S.A.R., with a foreword by James J. Waring, M.D., M.A.C.P., Professor of Medicine, University of Colorado School of Medicine. 308 pages with illustrations. Year Book Publishers, Inc., 200 E. Illinois St., Chicago 11, Illinois. Price \$6.00.

BIOGRAPHY OF AN IDEA: The Story of Mutual Fire and Casualty Insurance. By John Bainbridge. 381 pages. Doubleday & Company, Inc., Garden City, New York. Price \$4.00.

THE EPIDEMIOLOGY OF HEALTH: A New York Academy of Medicine Book, Iago Galdston, M.D., Editor. Published by Health Education Council, Number 10 Downing Street, New York 14, N. Y. 197 pages. Price \$4.00.

HEART AND CIRCULATION: DIAGNOSIS AND TREATMENT: By Meyer Sclar, M.D., F.A.C.C., Chief in Cardiology and Senior Attending Physiican Unity Hospital; Consultant in Cardiology Rockaway Beach Hospital and Madison Park Hospital; Associate Attending in Medicine and Cardiology, Kings County Hospital; Brooklyn, N. Y., Assisted by Jacob Melnick, M.D. 357 pages. Price \$7.50.

THE ROOTS OF PSYCHOTHERAPY: By Carl A. Whitaker, M.A., M.D., Professor of Psychiatry and Chairman of the Department of Psychiatry, Emory University Schol of Medicine, and Thomas P. Malone, M.A., Ph.D., Assistant Professor of Psychiatry and Director of Research, Department of Psychatry, Emory University School of Medicine. 236 pages. The Blakiston Company, New York and Toronto. Price \$4.50.



A. M. E. F.

Georgia A.M.E.F. Fund

The following physicians, listed by county medical society, have contributed to the AMERICAN MEDICAL EDUCATION FOUNDATION in April, May and June, 1953. Those making their contribution direct to the AMEF Headquarters may not be listed unless official notification has been received therefrom.

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an ERRONEOUS IMPRESSION

The Hospital Construction Program that has been in progress in Georgia since 1947 has to date provided 33 new hospitals and has been the means of enlarging and improving several existing hospitals. Approximately 11 new hospitals are still under construction and seven hospitals are in the planning stage. Since the beginning of this program, some sixty-odd additional physicians have been attracted to the communities where these new hospitals have been completed or are under construction.

Such progress, however, has not been without various attendant difficulties. For example, in some quarters of the State certain physicians have hesitated to close down clinics or small hospitals when new or enlarged hospitals have been completed and put into operation by the community. There seems to be an impression that in case a new hospital does not succeed and it becomes necessary to close the new institution that physicians or other interested persons may purchase the new hospital building for a very small price.

The Federal Act authorizing grants-in-aid to hospital and public health projects provides that if any facility for which funds have been paid under pro-

visions of the Act shall, at any time within 20 years after completion of construction be sold, leased or transferred to any person, agency, or organization, which, (1) is not qualified to file an application under the Act, or (2) which is not approved as a transferee by the proper State Agency, or (3) if it ceases to be a non-profit hospital, the Federal Government shall be entitled to recover from the transferor or transferee an amount bearing the same ratio to the then value of the hospital as the amount of the Federal participation bore to the original cost. A similar restriction on future use of the facility is contained in the State Act authorizing state grants.

There are indications that in some areas in Georgia physicians are not properly supporting some of the new hospitals with the possible motive of eventually purchasing the new hospital using it for their own personal ends, should it be forced to close. As explained above, any physicians or other persons who might acquire a new hospital would have to pay as purchase price the amounts determined in accordance with above mentioned provisions of the Act, before they could secure use of the hospital for other than non-profit purposes.

semi-charity service

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hospital

As a further step in the development of Emory University Hospital as a teaching hospital, an increasing number of beds are being utilized for part-pay patients who are unable to bear the full cost of hospitalization. These patients are under the supervision of the Chiefs of the Medical and Surgical Services at Emory University Hospital, who are designated by the Chairmen of the Departments of Medicine and Surgery of the Emory School of Medicine. The patient care on these services is the primary responsibility of the Chiefs of Service who delegate responsibility to the medical and surgical resident staff, with daily teaching rounds held by members of the two departments. A consultation service is also available in order that all type problems may be given specialized supervision. These consultations are available without cost to the patient,

and are encouraged because of the obvious benefits derived therefrom, both for the patient and for the house staff.

Patients on these services are referred by private physicians throughout Georgia and surrounding states, are admitted only at the request of their physician, and are discharged to the care of the referring physician. There is no charge for the professional services rendered to these patients, since the financial need of the patient must be such that he is unable to pay the full cost of medical care. However, the patient will be expected to pay eighty-five (85) per cent of the hospital bill, payment of which is required upon dismissal of the patient.

Such a service should be attractive to many of the physicians in Georgia, who may desire reduced cost medical and surgical facilities for some of their more complicated problems among the low income group of patients. The referring physician is assured that the Chief of the Service to which the patient is admitted will accept direct responsibility for the care of the patient, and will see to it that the appropriate resident staff conducts the care of the patient with the best medical and surgical principles. At the conclusion of the patient's hospitalization, a complete summary of the history, physical findings, laboratory and X-ray studies, opinions of consultants, course in the hospital and recommendations for further treatment will be sent to the referring physician to aid

him in the further management of the patient.

Mechanics of Admission

The admission of patients will be determined by the Chiefs of Service and the Superintendent of Emory University Hospital. Medical indications for admission will be routinely handled by the Chief Medical Resident or by the Chief Surgical Resident or the designated assistant residents. The financial indications for admission will be handled by the Assistant Superintendent of the hospital. The details of the mechanics of admission are as follows:

1. A referring physician writes or calls the hospital and talks to the Chief Medical or Chief Surgical Resident as his case may suggest. In the absence of chief residents, their designated assistants accept the calls.
2. The resident then notifies the Assistant Superintendent of the hospital that the patient should be admitted to either the General Medical Service or to the General Surgical Service.
3. The Assistant Superintendent makes such investigations as he may deem necessary, and if he determines the financial considerations warrant admission to one of the General Services, he then arranges for a bed and notifies the resident and patient as to the date of admission.

Physicians throughout the state are invited to recommend their low income patients for admission to these services as indicated.

present status of PHENYLBUTAZONE THERAPY

Phenylbutazone is a complicated compound structurally resembling aminopyrine. It has been in wide use throughout the United States for the past two years and has proved to be very effective in the relief of pain and inflammation due to gout, rheumatoid arthritis, osteoarthritis, rheumatoid spondylitis and associated rheumatic conditions. Recently several reports of toxic reactions have appeared. Some of these have been quite serious and a few fatal. It has become necessary to review the situation to see if we should continue to use this drug, and if so what precautions should be taken.

The incidence of toxic reactions has been reported in rates varying from 25 per cent to 44 per cent. Most of these were mild and probably less than 10 per cent could be classed as very serious. For some reason phenylbutazone causes salt and water retention. Usually this is manifested even in the absence

(butazolidin)

of heart disease simply by edema and weight gain and can be easily controlled. It may be serious, however, and cases of acute pulmonary edema have been reported. Ascites, peripheral edema, dyspnea and various degrees of heart failure have also been reported.

Gastrointestinal symptoms have been most frequently produced. This may be simple nausea, vomiting or epigastric pain or burning. Cases of duodenal ulcer being caused or reactivated have been seen and have been observed to heal after the drug was discontinued. Gastric ulcers, gastric hemorrhage and multiple gastric ulcerations have been observed after

phenylbutazone therapy. At least two cases of perforated duodenal ulcers and one perforated gastric ulcer have occurred. None of the patients had a previous history suggesting peptic ulcer.

Various degrees of bone marrow depression have been produced. Fortunately most of these were mild and recovered when the drug was stopped. Agranulocytosis, granulocytopenia and anemia comprised most of this group. At least two deaths have occurred from agranulocytosis. Other toxic effects that have been reported were fever, chills, dermatitis and one case of mild hepatitis.

Since phenylbutazone has proven to be an effective agent, its use should probably be continued. However, the high percentage of side reactions makes it imperative to give these patients special attention. The following precautions are indicated in selecting and following the patient:

1. Do not give to patients with a history of repeated cardiac decompensations. If the patients have heart lesions, hypertension, or are very old, they must be supervised very carefully. They should have rigid salt restriction, be weighed daily, and mercurial diuretics administered with the first appearance of edema. Patients with cirrhosis or active liver disease should be subjected to the same precautions. It would

be safer to use some other drug if possible in treating this group.

2. Active ulcers of the gastriontestinal tract constitute a definite contraindication to the use of this drug. A history of healed ulcer requires the doctor to watch the patient carefully for symptoms of reactivation.

3. Regular, complete blood counts are essential. These should be done once weekly for several weeks and slightly less after that. The blood counts should be continued one month after therapy has been stopped.

4. Routine regular urinalysis is indicated to watch for renal damage and especially for hematuria.

5. Discontinue the drug immediately if any signs or symptoms of toxicity occur.

6. Use as small a dose as possible. There is evidence that the early recommended dose of 800 mg. daily is not always required. Some patients get equal relief with as little as 400 mg. daily.

With these precautions, phenylbutazone can be used when definitely indicated, with a minimum of danger to the patient. All other anti-rheumatic agents should be exhausted before it is considered for therapy.

remember your A. M. E. F. CONTRIBUTIONS

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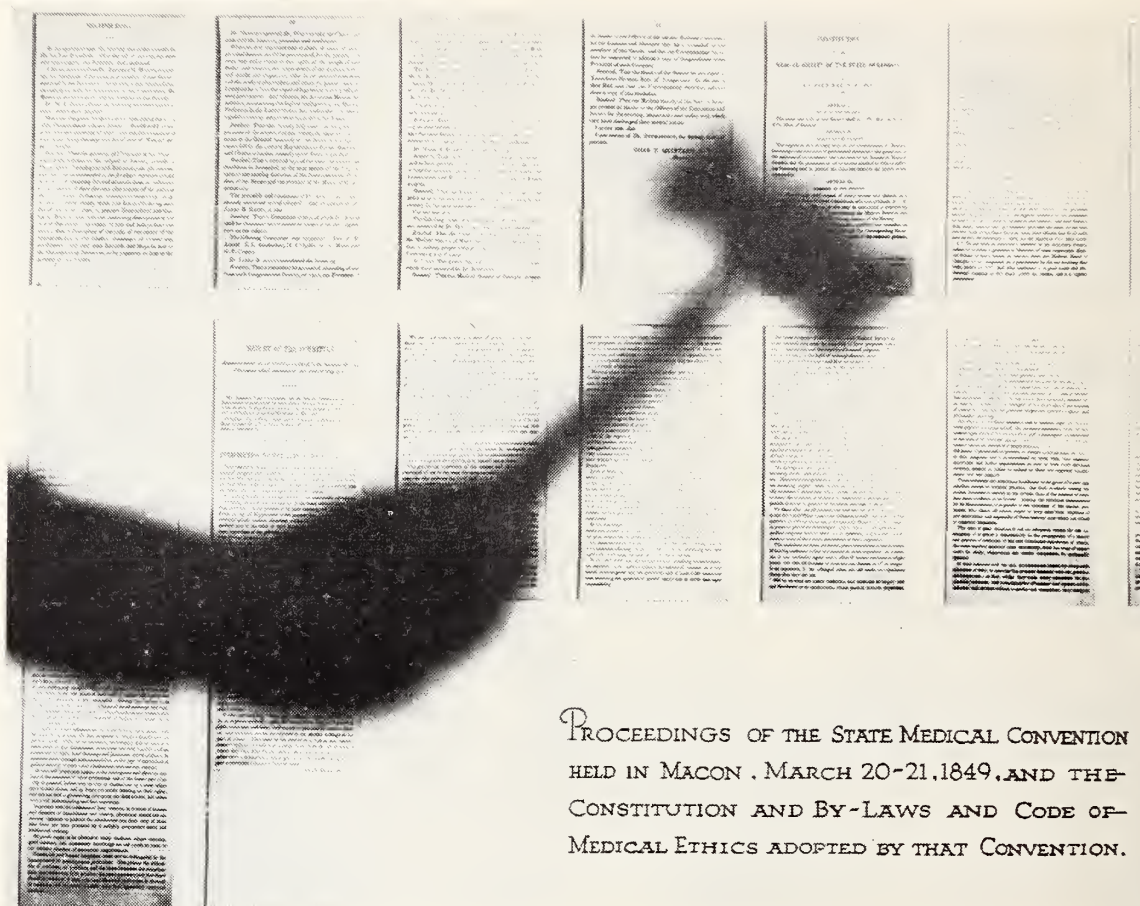
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PRESIDENT'S ADDRESS

from the 103rd ANNUAL SESSION

CORNELIUS FULMER HOLTON, M.D.

The past year has been an eventful one. We have seen the spectre of socialized medicine pushed to the background by the vote of the people last November. It must be remembered, however, that the danger is not over. We have simply gotten a respite in which to correct the situations which led up to the clamor for socialistic practices, by placing our own house in order. We must face the fact that there are a great many people who need medical services and cannot pay exorbitant prices. We must make some provisions to care for that class of our citizenry. Unless we do it through our own medical organizations we will surely be faced with another fight, and we may lose the backing of our friends in high places the next time.

History has a habit of repeating itself. Exactly 40 years ago in this same hall Dr. W. C. Lyle, of Augusta, then secretary-treasurer of the Medical Association of Georgia, in his annual report used the following sentences: "The recent medical agitation in England is making its influence felt in America and efforts will be made during the present session of Congress to pass certain laws containing certain of the English plans and eventually leading up to a fixing by law of the fees of physicians upon such a low scale that living under present conditions would be reduced to a bare existence. This may seem rather far fetched but unless the profession unites and takes time by the forelock we will have within the next five years such a fight on our hands as few have ever dreamed of."

Dr. Lyle did not know what a good prophet he

was. Those remarks would have been up to date in any medical journal last year. Fortunately the conditions in England changed and the fight for socialized medicine in America died away. It will not die again unless we succeed in correcting the things that bring it up.

When I assumed the presidency of this association I flattered myself that I knew most of the doctors in Georgia. I quickly became disillusioned and found I only knew most of the old codgers like myself. In my travels throughout the state I found a most peculiar situation. It seems that the membership of the district medical societies is composed mostly of mere youths of 35 or 40. Another thing that amazed me was that the members of the Women's Auxiliary were a lot of sorority girls masquerading as doctors wives. I found that these medical children were doing an excellent job. They were actually practicing good scientific medicine and surgery and were not at all reluctant to talk about it. I found also that the state had become literally sprinkled with modern up to date hospitals under the Hill-Burton Act aided and abetted by the splendid efforts of our Governor. How fortunate we are at present to have such sympathetic aid from our own state leaders. Under the new state aid plan for needy medical students we will be able to wipe out the stigma of having entire counties without a physician. Furthermore those physicians will have access to first class hospitals where their patients may receive first class attention. The days of the horse and buggy and the Model T Ford are gone. The Tobacco Road has been paved and its dubious citizenry is vanishing along with its illiteracy and incest. There are no more "Country Towns." From Attapulugus to Rising Fawn and from Thunderbolt to Rabun's Gap they are now Country Cities and are definitely Cadillac and television minded.

I have during the year visited all the districts in Georgia and I'll venture to say that I have looked longingly at more nine hole golf courses than any one else and I have eaten more drum sticks than a trail riding Methodist preacher.

It has been a grand experience and I have enjoyed it immensely. By a delightful coincidence, when I surrender my gavel two days from now it will mark to the day exactly forty years since I received my diploma in medicine and was granted the right to inflict my knowledge, or lack of it, upon the citizens of this great state. I cannot refrain from looking backwards and discussing some of the advances made in medicine during those four decades.

In 1913 some of our most pressing medical problems were conditions which have by now been completely eradicated or practically so. I will not go into details but will touch briefly upon some of them.

Hookworm was a scourge. It has practically vanished. Typhoid fever was an annual plague which wiped out the lives of many of our children and adults. None but the older ones among us can remember the dramatic surgical emergencies due to reputed ulcers in Peyers patches. I doubt if many of the younger men even ever heard of that area of

our intestines. Pellagra was prevalent and deadly. Some of the most important work in the etiology and treatment of that disease was done at the Public Health Hospital in Savannah by Goldberg. Malaria was the greatest cause of morbidity and economic losses in the state. In 1935 there were 137,502 reported cases with 4,207 reported deaths in Georgia alone. In our own clinic at nearby Richmond Hill we had 105 cases in September of 1936 with one death. Malaria is practically extinct. In 1940 the Maternal mortality was 342 compared to 140 in 1950. Tuberculosis, once the great killer, is being slowly but surely conquered. A few years ago the state was ridden by Brills Fever. Through rat control programs this disease is becoming a rarity. Diabetes is being brought under control by clinics and education. Cancer is still present but it is being diagnosed early and many cases which would have been doomed forty years ago are being cured by early surgery or radiation. Great work is being done by the cancer societies and clinics and I have no doubt it will eventually be conquered. Due to the decline in other killers heart disease is now given top ranking. It too is under a frontal attack by the many heart clinics which have been set up throughout the state where these sufferers may receive expert advice.

Forty years ago venereal disease was a number one social and medical problem. Syphilis was the greatest single cause of heart disease, insanity, stillbirths, miscarriages, idiocy and deformities in children. Gonorrhea was the causative factor in thousands of mutilating operations in the females. One pregnancy sterility was extremely common. These were HUSH HUSH diseases and could not be mentioned in polite society. Thank God the veils of hypocritical secrecy have been torn apart and these loathsome conditions exposed to the sterilizing sun light of publicity. With education, mass public surveys and the advent of penicillin these disease are on the way out. At a recent meeting of dermatologists in Chicago they brought out a person with an initial syphilitic lesion. It was the first one many of those skin specialists had ever seen.

Nothing is ever gained from a war except advances in medicine and surgery. We have had two major wars during the past forty years and if we are not having another one now I am at a loss to find a name for the things taking place in Korea. World War One proved that mass inoculations would prevent typhoid and that tetanus antitoxin given at first aid stations would prevent tetanus in most of the cases. Many advances in surgery, particularly in the treatment of fractures were made. World War Two brought many additional advances, particularly in the internal fixation of fractures of the long bones, prevention of shock by field administration of blood and plasma and many aids in the treatment of malaria and typhus.

The treatment of burns received great stimulation due to the many severe cases seen by the air force and front line hospitals. Much yet needs to be learned.

During those many years since I graduated we have seen revolutionary changes in Anaesthesia and perhaps this department of medicine has made the greatest strides in the past decade. It is a far cry from the open drip ether method and the early Gwathmey gas oxygen anesthetics to the present methods. Massive surgery in the chest and abdomen is now possible when such procedures would have been surely fatal if attempted before anaesthesia came into its own.

When I was an intern a blood transfusion was a major operation with not infrequent mortalities from blood not being compatible. Today it is as routine as postoperative hypodermics and about as safe.

The development of the sulfonamids and antibiotics have completely changed our treatment of such diseases as pneumonia, mastoiditis, meningitis, venereal diseases and many others. These were once deadly killers but are now being tamed.

Forty years ago every city of any size had a pest house where small pox victims were incarcerated. Few of our more modern doctors have ever seen a case of small pox much less a pest house.

Our mental cases in those days languished in county jails until a bed could be made available for them at the state asylum. Once there they were practically doomed to remain as few of them had any treatment worthy of the name. The advent of modern psychiatry with better diagnoses, shock treatment of all kinds and better general care in a first class hospital instead of an asylum has returned many of these unfortunates to their families and their jobs.

Polio is a dread disease and strikes without warn-

ing. Much progress is being made and it will inevitably be banished.

Appendicitis was a great killer due to late diagnoses and much morphia. Even the lay people now make diagnoses of appendicitis and seek aid early. The mortality has dropped tremendously but some still die because of lack of early surgery.

Yes, Medicine Marches On.

Our medical schools are struggling against great financial odds. Pressure is being brought upon them to accept federal subsidies. Should they ever do that then the federal government can regulate them. The American Medical Association Educational Fund is doing everything in its power to bring financial aid to these schools and is spending thousands of dollars in this program. It is up to us as doctors to do our part by contributing yearly to this fund.

It has been an interesting and happy forty years for me.

The longer I live the more I realize that everything is relative. I see in this audience a rather large number of doctors who have been practicing medicine for fifty years. Praise God they are here, because those fellows look upon me as just another big mouth youngster.

I have talked enough. I am probably the last of the old timers to occupy this exalted office. A new order ariseth. *L'Roi et Mort; Vive L'Roi.*

On May 13th, 48 hours from now, I shall wrap the draperies of my couch about me, and with faith in the future and pride in my heart, join that distinguished group of elder statesmen of medicine, the past presidents of the Medical Association of Georgia.

Facts on Medical Education

In some circles there is a belief that medical education is lagging and is out of pace with the needs of the time—and that the only solution is a vastly extended system of government grants and subsidies.

The American Medical Association has now published a "Factbook on Medical Education" which does a first-class job of refuting that idea.

As the booklet's title implies, it is full of factual data concerning the medical education system as it exists today. It deals with the experience during the 1951-52 school year as contrasted with prior periods. A summary of the facts is given in these words: "Medical education, during the academic year of 1951-52, recorded these accomplishments: The largest medical school freshman class in history. The

largest medical school four-year enrollment in history. The largest graduating class, while on regular schedules, in history. The greatest increase in teaching facilities in history. The best financial support of medical schools in history." It also points out that medical education is more than keeping up with population changes—from July, 1942 to July, 1952, the population increased 16.4 per cent while medical school enrollments jumped 22.8 per cent.

In short, the nation is getting more doctors and extremely well-educated doctors. This is one more example of how our medical care problems are being attacked and gradually solved—without making the government banker and boss and thus opening the road to socialized medicine.

SCROTAL GANGRENE

and PHAGEDENIC PENILE

ULCERATION *Associated with Large*

INTRAPELVIC ABSCESS:

Fatal Case Report

Fournier's gangrene of the scrotum was described in 1884.¹ The condition may affect any age group.² It is characterized by explosive onset in an otherwise healthy man, rapid progression of the gangrene and total absence of usual causes of gangrene. Mansfield, in 1946, summarized two additional features common to published reports of this type of scrotal gangrene, namely, an extensive and fairly constant area of gangrenous involvement; rapid resolution of adjoining cellulitis, together with a corresponding improvement in the patient's general condition when the sloughing area has separated; and a tendency for spontaneous repair to occur.¹ Of 206 cases collected from the literature by Gibson in 1930, two groups could be differentiated: one in which a coincident or antecedent lesion could be noted (not "true" Fournier's gangrene) and another in which no associated pathology was identifiable (98 cases of "true" Fournier's gangrene).² The average time in Gibson's series from onset of symptoms to development of scrotal gangrene was three days. The time between first scrotal symptoms and death varied from 36 hours to three days. Total mortality was 26.7 per cent of 187 cases of which the final outcome was known.²

A similar condition was reported in a female who suffered gangrene of the right half of the vagina, right buttock, right upper thigh and most of the suprapubic skin as a result of an ischio-rectal abscess.³ Toxemia was emphasized as the cause of death in that patient. Only two other comparable

case had previously been published.³

Randall summarized the literature on idiopathic scrotal gangrene up to 1920,⁴ Gibson up to 1930² and Browne and Smith up to 1939, at which time a total of 228 cases was collected.⁵

In 1949, Thorek and Egel described plastic surgical repair of the penis for gangrenous loss of phallic skin following circumstances.⁶ A pre-circumcision balanitis had been present; only two similar cases could be found in the literature by these authors. Other instances of gangrenous degeneration of penile skin secondary to circumcision have been reported,⁷ but pre-existing balanitis was not a factor involved in the postoperative catastrophe. A case of phagedenic ulceration of the penis, unrelated to any known etiological agent, was reported as responding well to prompt surgical therapy.⁸

Sporadic case reports of gangrenous denudation of the penis or scrotum have indicated associated, nearby pathology. Barclay and Hendrick cited the case of one patient who had deep thrombophlebitis of the left leg and infarction of the lower lobe of the right lung in conjunction with the scrotal gangrene.⁹ Goodwin and Thelen's case of penile skin slough was due to urinary extravasation.¹⁰ Ebrill and O'Donoghue published a "typical example" of Fournier's scrotal gangrene but did mention the existence of a small penile lesion, suggesting that organisms might have gained access through this route.¹¹ Other similar cases have been reported; reference is invited to the more recent of these.^{12 13}

ALEX L. FINCKLE, M.D., CHARLES L. PRINCE, M.D., and
PETER L. SCARDINO, M.D., Savannah



Figure 1.

CASE REPORT

E. P., a 42-year-old Negro was admitted to the Georgia Infirmary, Savannah, November 17, 1952 because his wife could not longer tolerate the foul odors which had emanated from his genitalia for two and one-half months. History revealed that until three months previously, health had been good. Without apparent cause "sudden swelling of all the privates" occurred. Ointment prescribed by a local physician was applied only once. This allegedly produced "drainage" from the scrotum. Thereafter progressive ulceration of the scrotum and of areas of dorsal penile skin ensued. No further treatment was sought while he lay in bed. No urinary or bowel difficulties were noted.

According to the hospital attendants, dirty handkerchiefs were wrapped around the genitalia at the time the patient entered the hospital. The odor of "rotten flesh" was pronounced. When the scrotal "dressings" were removed, innumerable maggots and flies were found upon the exposed testes and the partially ulcerated dorsal penile skin.

Past history and systems review were not contributory.

The only pertinent findings on physical examination were limited to the genitalia. The uncircumcised penis bore, at its mid-shaft, two slashes of ulcerated skin, exposing Buck's fascia for three cm. dorso-laterally on the right side. The totally necrotic, macerated, malodorous scrotum hung by a few shreds of tissue at the posterior scroto-perineal junction, leaving fully exposed the spermatic cords and testicles (figure 1). Rectal examination was negative.

The scrotum was readily snipped off with scissors, posteriorly, without need of anesthesia. A No. 20-F red rubber catheter passed easily into the bladder, *per urethra*, recovering 200 cc. grossly and microscopically clear urine. Red blood cell count was 4,230,000, white cell count 12,000 and the differential partition of leucocytes was normal. Serum non-protein nitrogen was 30 mg. per 100 cc.

Body imersions in dilute potassium permanganate baths were ordered thrice daily and dicrysticin (2 cc.) was given intramuscularly twice daily. Plastic repair of the scrotum was planned for November 27, 1952, following great improvement of the appearance of the genitalia. On that date, however, oozing of blood was observed through a perineal, para-anal opening. The external blood loss was negligible. Within three days a fluctuant area could be felt over the right ischial tuberosity. The erythrocyte count had fallen to 3,470,000. Incision and drainage of the fluctuant perineal area was done under local anesthesia, and only 10-15 cc. of seropurulent drainage escaped. Finger palpation within the wound demonstrated no abscess pocket. That evening 500 cc. of blood was given by transfusion. Two hours later the patient unexpectedly expired.

Autopsy was performed four hours after death by Dr. Lee Howard, Jr. The only significant finding was a large intra-peritoneal, right para-rectal abscess, containing at least 300 cc. of old blood, fresh blood and pus. It was believed to have originated from a right ischio-rectal abscess that had pointed internally.

SUMMARY AND COMMENTS

A 42-year-old Negro suffered sudden onset of "swelling of privates" which progressed within two weeks to complete scrotal necrosis and phagedenic ulceration of the penis. He entered the hospital three months after the onset of the disease. After marked improvement in the appearance of the penis and exposed testes, following cleansing baths and antibiotic therapy, he expired unexpectedly. Autopsy revealed a huge, intraperitoneal, para-rectal abscess that had pointed internally.

This does not represent a true case of "Fournier's scrotal gangrene." However, it is similar to a case reported by Thomas of a female who succumbed from gangrenous destruction of the genitalia secondary to a fulminating ischio-rectal abscess;³ and is much like the instance of scrotal gangrene associated with deep thrombophlebitis within the leg, described by Barclay and Hendrick.⁹

Discussion

The preceding case probably does not represent a true Fournier's scrotal gangrene. However, the history of application of ointment to the genitalia can not be regarded as corrosively causative of the subsequent gangrenous destruction of the scrotum and the partial degeneration of the dorsal penile skin. Many patients ascribe to certain trauma or chemical injury the initiation of the lesion, particularly of penile cancer. The present patient manifested phagedenic ulceration of part of the dorsal penile skin. According to Mansfield, the ventral penile skin may be involved, but not the dorsal, if the hypothesis of disturbed or thrombotic vascular supply were to account for the "constancy of the involved areas."¹

Diagnosis of intraperitoneal pelvic abscess was not established during life in this case. That it arose from an asymptomatic ischio-rectal abscess is speculative but reasonable. Just why this abscess progressed internally and pointed to the perineal skin only late, and to negligible degree, defies explanation. Unfortunately, no bacteriological cultures were made either at the time of incision and drainage of the perineum, or at autopsy. Therefore no organisms were identified. But the patient was not "toxic" at any time after antibiotic therapy was instituted initially. It is doubtful that toxemia caused death; a mycotic cerebral embolus would more like be at fault. Post-mortum examination of the head was not permitted.

Although Ebrill and O'Donoghue¹¹ could not apply Mansfield's theory of "septic embolism within the vessels of the scrotal septum"¹ to the distribution of the scrotal gangrene of their patient, that thesis of embolism appears to be the most tenable presented in the literature in explanation of this condition. Suggesting instead, that some "abnormal infection or symbiosis of organisms similar to the post-operative skin gangrene or to Meleny's burrowing ulcer" is responsible for scrotal gangrene¹¹ leaves much to be desired. In the present case, the external pudendal branch of the femoral arteries were not traced at autopsy. Nonetheless, from the size and location of the intra-pelvic abscess, it is likely that these vessels and the superficial perineal arteries were damaged

On Doctor Bills

Hats off to the *Alma Times*, of Alma, Georgia, for carrying a full page advertisement emphasizing that the public too often overlooks payment of doctor bills. The message campaigned for prompt payment of all bills—with special emphasis on the payment of doctor bills.

Progress in Coffee County

Coffee County again scores a public service in a drug store paid advertisement running in the *Coffee County Progress* which lists the phone numbers of doctors.

District News-Letter

Ninth District Medical Society publishes their own *News-Letter* and Directory which is sent to all members. Carrying short newsy items of information in the district, this publication fills a definite need in the organization. Edited by George T. Nicholson, Sec'y and Treasurer and Mrs. Nicholson; the staff of the *JMAG* and the *MAG* headquarters office wish to add their compliments to the *News-Letter* staff.

or compressed, thus accounting for the absence of even small scrotal remnants.¹

Despite the fact that 70 years have elapsed since Fournier first described idiopathic scrotal gangrene,

little light has been cast upon its etiology. Although relatively uncommon, this alarming problem deserves further study.

Summary

Literature pertaining to Fournier's scrotal gangrene, to scrotal necrosis associated with nearby infectious processes, to penile skin slough as a complication of circumcision and to phagedenic ulceration of the penis has been reviewed. A case of total loss of the scrotum with partial, necrotic ulceration of penile skin was presented. Mansfield's theory of "vascular dissater of infective origin" was favored for explanation of this problem, although all-inclusive etiology is still unknown.

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Summer in the Garden

I shall not think now of the world that goes
Beyond the boundaries of this summer day
Here in my garden: cathedrals of the rose,
Proud minarets of larkspur, phlox that lay
Their tight-shut eyes to rest along the grass.
I shall think on the four o'clocks' red flowers,
Bluebells that ring a moment and then pass
Their music to the wind. These are the hours

That feed my soul like wine and broken bread,
That give my heart a staff to lean upon,
Provide a pillow for my weary head.
I shall think on the world, its steel and stone,
Man and his hates, his perils and his war
Some other day when summer sings no more.

—Daniel Whithead Hicky

By a law passed in 1937¹ the Georgia Legislature provided for the sterilization of persons in state hospitals, colonies, or correctional institutions, if they have certain forms of undesirable heredity. If the children of a patient or inmate are apt to inherit serious physical, mental, or nervous disease or deficiency, the superintendent of the institution is to submit to the State Board of Eugenics a recommendation for the prevention of such parenthood. This Board consists of the Directors of the State Board of Health and the State Welfare Department, together with the Superintendent of the Milledgeville State Hospital. If the Board finds that there would be a tendency to such inherited disease or deficiency, it approves the recommendation and notifies the superintendent.

The law specifies that the operation shall be one such as vasectomy or salpingectomy, which will not unsex the patient. The interests of the patient are protected by the right to appeal to the Superior Court if he objects to sterilization, and he is allowed to choose the surgeon who is to perform the operation.

The first sterilization under the law was performed in 1938. By the end of 1947 the total had risen to 447. Owing to increasing appreciation by the superintendents of the valuable results of protective sterilization, the rate has been higher recently. There were 134 such operations at the Milledgeville State Hospital in 1948, 140 in 1949, 154 in 1950, and 125 in 1951, making the total at the end of that year 711 sterilizations of psychotic patients, plus 427 sterilizations of mental defectives at Gracewood School for Mental Defectives.

Sterilization of the Psychotic

At the Milledgeville State Hospital there have been 711 sterilizations, of which 69 were performed on male patients. The diagnoses which led to the protection of patients from pregnancy were: psychosis with mental deficiency 190, dementia praecox 347, manic-depressive psychosis 83, psychosis with epilepsy 55, and various others 36. The ages have varied from 12 to 50 in a mentally deficient sexual psychopath, the mean age being 28.

Prior to sterilization, these 711 patients had borne 856 children. From the number of reproductive years still ahead of them, the estimate that they might have produced a further 856 children seems justified. To spare these 856 the risk of unfavorable inheritance and the certainty of unsatisfactory upbringing by a mentally abnormal parent is an important accomplishment.

More immediate and tangible results are found in the fact that 302 of these sterilized patients have been furloughed 483 times, for a total period outside of the institution of 258 years. Many of these furloughs would not have been possible without the assurance that the patient would not become pregnant.

It is difficult to estimate the completeness of the sterilization program in Georgia.

*Superintendent, Milledgeville State Hospital.

GEORGIA Program for STERILIZATION

T. G. PEACOCK, M.D., Milledgeville

Obviously there are many patients discharged for whom sterilization is not appropriate because of the mildness of the disease or their age or infertility. Those with arteriosclerotic psychosis or paresis are seldom in the fertile period of life. Schizophrenia and manic-depressive psychosis are probably the mental disease in which protection is most indicated.

At the Milledgeville State Hospital the demands on the time of the operating room and the surgeon for more acute surgery have been such that the number of sterilization has been smaller than would otherwise have been the case. For much of the time 50 or more patients have been on the waiting list. During 1951, 390 patients were discharged from the Milledgeville State Hospital with the diagnosis of schizophrenia. Of these 63 had been sterilized. Of the 350 with manic-depressive psychosis released in the same period, 19 had been subjected to tubectomy.

At the Gracewood School for Mental Defectives 427 patients have been sterilized. In a study of the children of the feeble-minded sterilized at the Laconia State School in New Hampshire,² it was found that 36 per cent were themselves feeble-minded. From the birth rates before the operation, it was concluded that each 100 sterilizations of females and each 200 of males would prevent the birth of 90 feeble-minded children. If these proportions apply to the patients at Gracewood, there will be 474 fewer feeble-minded Georgians because of the 427 who were protected from parenthood.

At the Gracewood State School sterilizations have been limited by the fact that these have had to be arranged for outside the School. The resulting cost has been such that the budget for surgery has not been adequate for all the tubectomies which were desirable.

Sterilization Is Without Sacrifice

In considering the use of any public health measure the cost must be considered. For sterilization it is minimal. The operation is not a serious one, and except for the prevention of children there is no alteration of bodily functions. The presumption that tubectomy, which does not interfere with or remove any gland, causes no alteration in sexual characteristics or desires has been supported by numerous investigations. In a recent study³ of 48 sterilized women in North Carolina, the five who believed there was some decrease in sexual activity were outnumbered by eight telling of an increase. In a similar series⁴ of 50 vasectomized men, the five reporting a

decrease were more than balanced by nine who stated there had been an increase.

Psychotic Person Are Unsatisfactory Parents

The protection of potential children from the risk of inheriting unstable minds is not the only advantage of the sterilization of mentally diseased patients. We who administer the state program believe that those with psychotic episodes are not fit to rear and care for children. The children are certain to be poorly conditioned by the unfavorable parental surroundings.

The fact that psychotic parents are incapable of rearing children properly should be given ample consideration in the discussion of possible sterilization. The Board of Eugenics often points out to the families that patients recommended to them may become chronically insane and therefore unsatisfactory persons for the upbringing of children.

Sterilization has an additional value in some cases in that a pregnancy is likely to cause further mental disturbance. We have numerous patients who were released without sterilization, only to be brought back to the hospital by new episodes precipitated by further pregnancies. There is one, for example, who is now apt to be a permanent inmate. She has a record of seven pregnancies with a schizophrenic episode following each one. Three of the children were born in the Milledgeville State Hospital. She has now been sterilized, but most of the horses are out of the barn.

Many of our case histories show the connection of dementias with pregnancy. There is, for example, Mrs. B. A. Her first schizophrenic episode came during her third pregnancy at the age of 35, and the next, which followed an abortion, brought her to the hospital. A subsequent furlough ended when a fifth pregnancy brought a recurrence in which she beat her children without cause, tried to choke them and threatened to kill them. Sterilization is planned.

Another, W. L. B., had been able to adjust after a period of auditory, visual, tactile and olfactory hallucinations. Marriage and a pregnancy, however, brought a recurrence. She has never been able to care for the child, which her hospitalization left to the grandparents and the Aid to Dependent Children.

Mrs. M. B. experienced her first schizophrenic upset following the birth of her first baby at the age of 21. She was delusional and hallucinatory, lost interest in the home, and refused to care for the children. She was careless with fire. After her third child, she was admitted to the hospital. A furlough, against advice, resulted in a pregnancy and twins after readmission. She is violent and antagonistic toward the five children who are being cared for by various relatives, while she is still in the hospital.

The difficulties of children of the psychotic patients are illustrated by Mrs. M. M. K. Her mental upset began at the age of 28. She was reported as wandering around the community and unable to care for her three children. She attempted to kill one of them by putting him under the water hydrant. At the time of admission she was delusional and confused, and was found to be mentally deficient as well as psychotic. A month later a fourth child was born to join the unfortunate group. That heredity was an important factor is suggested by the fact that her

sister had a "nervous breakdown" associated with pregnancy.

Another unsatisfactory mother is Miss L. S. Episodes of destructiveness and violence toward her family and her illegitimate child required her admission at the age of 23. She experienced periods of excitement and others when she was most fearful. Two hospitalizations of four months each did not give permanent stability, and she was readmitted in a second pregnancy. The future of the resulting baby, delivered in the Hospital, was brightened by the child being placed with adoptive parents. At present, six years after the first admission, the mother is still unable to adjust at home because of recurrent episodes of violence.

Four children of Mrs. T. A. W., who suffers from schizophrenia of the catatonic type, are being cared for by the Floyd County Open Door Home, because the patient is delusional, hallucinatory, violent and combative. Her current pregnancy, in the sixth month of which she was admitted, will add another problem to those of Georgia's charitable agencies.

These abstracts of acute cases, typical of many coming to state hospitals, indicate the emotional traumas which psychotic parents inflict upon their children, and show the deleterious effect of multiple pregnancies on some of the psychotic patients. Anyone who has spent years in such hospitals will have seen the effects of many such cases. Were one able to visit the homes of the discharged patients, it would be found that these represent only a small fraction of the total psychic damage done to the next generation. For that reason we contend that there should be a thorough program of sterilization for therapeutic and prophylactic as well as for eugenic purposes. Diagnosis is often made too late to prevent the childhood tragedies of the early children of psychotic patients, but in cases in which mental disease will be permanent, we can and should prevent further disasters. A majority of the children of such patients may escape inheriting the psychosis, but psychic damage to each is inevitable and even with the best of countermeasures it is often severe.

Sterilization Protects the Public,

the Patient and Potential Children

We do not claim that our program in Georgia is complete. We feel it is almost trying to sweep back the ocean with a broom. During 1949, however, Georgia protected 4.3 psychotics from parenthood for every 100,000 population, and in this respect led the nation. In 1950 the rate was again the highest of any state, being 4.5. In 1951 Georgia's rate of 3.6 was exceeded only by North Carolina (fig. 1).

We believe that we have saved the state thousands of dollars by being able to discharge numbers of patients who could not otherwise have gone home. Large additional sums have also been saved for the future by the prevention of the hereditary transmission of unstable mentalities and of the creation of many such mental conditions by the surroundings which psychotic parents inevitably give.

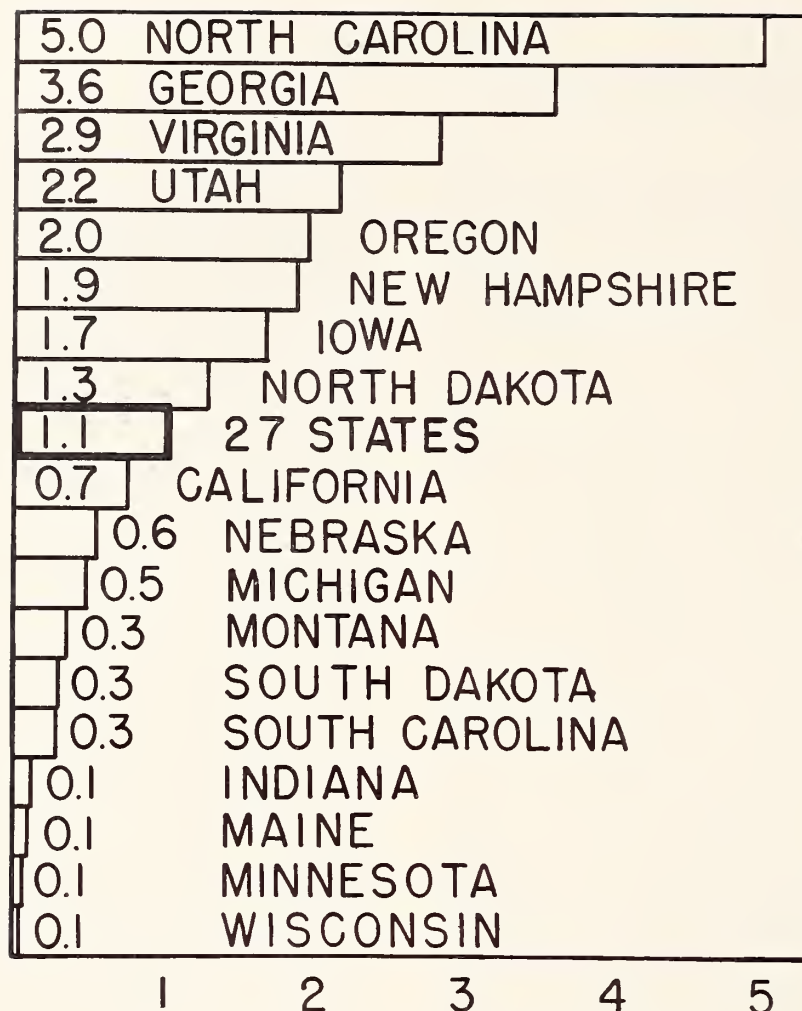


Figure 1. Sterilization of psychotic persons per 100,000 population reported by state institutions in 1951.

We have spoken of financial savings, made possible by sterilization, but far more important are the lifelong mental crippling which it can make unnecessary. While they are invisible as are the typhoid deaths prevented by chlorination of a water supply, they are of great importance to the future of our people and our nation.

Summary

Georgia's sterilization law has protected 711 psychotic and 427 mentally deficient persons.

It is estimated that it has prevented the birth of 856 children to mentally diseased parents and 856 children who might have been feeble-minded.

Studies of sterilized persons show that the few reporting a decrease in sexual activity are exceeded

by those telling of an increase.

Sterilization shows additional furloughs, decreasing taxes and increasing freedom for the patient.

It has prophylactic value in protecting patients from psychotic episodes induced by pregnancy, and in shielding children from mental trauma by psychotic parents.

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Each M. D. Donates \$3,000

A nation-wide survey by *Medical Economics* magazine indicates that the average U. S. physician spends 12 per cent of his working time on patients who cannot pay. The dollar value of this work is estimated at more than \$3,000 a year per doctor.

According to the survey, seven out of 10 doctors do some work they do not expect to get paid for. Big-city physicians and those with high incomes do more than small-town physicians with less earning power.

MEDICAL ASSOCIATION
OF
GEORGIA

OFFICIAL
PROCEEDINGS

from the

103rd ANNUAL SESSION,

Savannah, May 10-13, 1953

First Session, House of Delegates
Sunday, May 10

The House of Delegates was called to order by President C. F. Holton at 10:00 a.m. in the Gold Room, Hotel DeSoto, Savannah.

Upon motion duly made and seconded, Credentials Committee Chairman John Elliott accepted the official delegate's attendance slip in lieu of a roll call as an official attendance record, and reported a quorum present.

ATTENDANCE

The following official delegates were in attendance: BIBB—J. D. Applewhite, J. B. Kay, Sam Patton, T. L. Ross, Jr., and J. B. Stewart; GEORGIA MEDICAL SOCIETY—John L. Elliott, Ruskin King; CHEROKEE-PICKENS—C. J. Roper; CLARKE—M. A. Hubert and John A. Simpson; COBB—Charles Garland; CRISP—P. L. Williams; DECATUR-SEMINOLE—Edwin M. Griffin; DEKALB—W. K. Kerr; FLOYD—C. J. Wyatt, Jr.; FORSYTH—Marcus Mashburn; FULTON—John S. Atwater, Donald E. Bickers, Edgar

Boling, Stephen T. Brown, Shelley C. Davis, Murdock Equen, William E. Goodyear, Harry Lange, A. H. Letton, Jack C. Norris, J. H. Patterson, A. C. Richardson, Paul L. Rieth, C. Purcell Roberts, J. Harry Rogers, Lester Rumble, Jr., B. L. Shackelford, Duncan Shepard, Henry E. Steadman, John W. Turner, Exum Walker, John R. Lewis, Jr., and Charles P. Yarn, Jr.; GORDON—L. R. Lang; GWINNETT—D. C. Kelley; HABERSHAM—J. J. Arrendale; HALL—Cullen McCarver, Jr.; HART—J. Hubert Milford; JENKINS—A. P. Mulkey; McDUFFIE—A. G. LeRoy; MUSCOGEE—Frank B. Schley and L. J. Roberts, Jr.; NEWTON—Clarence B. Palmer; POLK—W. H. Lucas; RABUN—George H. Boyd, Jr.; RICHMOND—Thomas Goodwin, R. C. McGahee, D. R. Thomas, Jr., and G. W. Wright; SOUTH GEORGIA MEDICAL SOCIETY—A. G. Little; SPALDING—Virgil B. Williams; THOMAS—George R. Dillinger; TROUP—Charles T. Cowart; UPSON—T. A. Sappington; WALKER-CATOOSA-DADE—Fred H. Simonton; WALTON—S. J. DeFreese; WARE—W. L. Pomeroy, and Leo Smith; WASHINGTON—B. L. Helton; WHITFIELD—G. L. Broadrick.

Also in attendance were Past-Presidents Frank K. Boland, William R. Dancy, C. H. Richardson, Clarence L. Ayers, Allen H. Bunce, Ralph H. Chaney, Enoch Callaway, A. M. Phillips and W. F. Reavis.

Officers present were C. F. Holton, President; William P. Harbin, Jr., President-Elect; Rudolph Bell, First Vice-President; David H. Poer, Secretary-Treasurer.

AMA Delegates C. H. Richardson and Eustace A. Allen were present.

Councilors George R. Dillinger, W. G. Elliott, J. W. Chambers, Marion C. Pruitt, H. Dawson Allen, D. L. Wood, Sage Harper, W. Bruce Schaefer, and H. L. Cheves were present.

Vice-Councilors in attendance were Clarence B. Palmer and John W. Turner.

Also present were Howard J. Morrison, H. F. Sharpley, Ralph W. Fowler, W. S. Dorough, Lester M. Petrie, Spencer Kirkland, Tully T. Blalock, and Hoke Wammock.

President Holton announced that nominations for Speaker were in order, and Fred H. Simonton presented the name of Thomas W. Goodwin, Augusta, for the post. There being no other nominations, Goodwin was unanimously elected.

Speaker Goodwin then took the Chair, announcing that nominations for Speaker pro tem were in order. Clarence B. Palmer nominated Fred H. Simonton, Chickamauga. There being no other nominations, Simonton was declared elected.

Speaker Goodwin announced the next order of business to be the presentation of annual reports of officers and committees, a majority of which was printed and included in the official Delegate's Handbook. He then named the following reference committees:

REFERENCE COMMITTEES

Reference Committee No. 1: Enoch Callaway, Chairman, LaGrange; C. J. Wyatt, Jr., Rome; John W. Turner, Atlanta; Marcus Mashburn, Cumming.

Reference Committee No. 2: Ralph Chaney, Chairman, Augusta; Duncan Shepard, Atlanta; Ralph W. Fowler, Marietta; C. S. Pittman, Sr., Tifton.

Reference Committee No. 3: Fred H. Simonton, Chairman, Chickamauga; Frank B. Schley, Columbus; A. P. Mulkey, Millen; David R. Thomas, Jr., Augusta; William F. Reavis, Waycross.

Reference Committee No. 4: A. G. Little, Chairman, Valdosta; T. A. Sappington, Thomaston; Cullen McCarver, Jr., Gainesville; W. D. Hall, Calhoun; A. M. Phillips, Macon.

The Speaker, providing opportunity for amending all printed reports, called for presentation in the following order:

REPORT OF THE PRESIDENT

Cornelius Fullmer Holton

During the past year your president has traveled extensively and talked interminably. He has had the privilege of

attending meetings in all of the districts and has attended the annual meeting of the American Medical Association in Chicago and the special called meeting of the A.M.A. House of Delegates in Washington. In addition to these he has attended several county and special meetings in the state. He has attended all council and executive committee meetings and has been present for sessions of the Better Health Council and for the Conference of Secretaries and County Society Officers.

The district societies were found to be well organized and without exception well attended. The programs were excellent, both scientific and social. Many of the papers presented in the district meetings were of such high calibre that they could well be presented before state and national assemblies. The ladies were present in great numbers at each district meeting and it is our belief that the increased activity of the Women's Auxiliary is primarily responsible for the exceptional attendance at the district gatherings. More power to them. Your president has enjoyed his term of office exceedingly and he has had loyal support from a most capable council. His work was lightened by the whole hearted support of the executive secretary, the editor of the *Journal* and by the efficient and courteous members of the office staff in Atlanta.

The relations between the President and the Secretary-Treasurer have been one hundred per cent perfect. It is fitting that a tribute be paid to Dr. David Henry Poer. He is doing a job which is outstanding in efficiency and initiative and the amount of time which he devotes to his work is beyond comprehension. To him we all owe our heartfelt thanks.

COMMENTS AND RECOMMENDATIONS

1—It is felt by your president that a Board of Governors (or Board of Trustees), should be set up as a planning and policy making board for the Medical Association of Georgia. This board should be composed of seven men, the President, the President-elect, the Secretary-Treasurer and four immediate past presidents of the state association. It should meet at least once annually and should advise with the state officers, the council and with the house of delegates concerning present and future plans and policies for the state association. It should especially consider a long range housing plan for the association.

2—Legislative: It is not possible for a busy practicing physician to give the necessary time at the State Capitol, when the legislature is in session, to watch our interests in legislation directly concerning us. In addition to the physician members of this committee we should have a paid lay representative present at the Capitol throughout the sessions. This person to be one well informed as to the workings of our legislative bodies and with a wide acquaintance in the House and the Senate. He should work under and report to the Chairman of the Legislative Committee. The budget committee should include the necessary expenses for this representative in its report.

3—Executive Secretary: The present system is working out most satisfactorily and should be continued. Additional staff should be furnished as needed. The Medical Association of Georgia should purchase an automobile for the use of the Executive Secretary. At present he furnishes his own and we certainly should correct this situation.

4—Annual Sessions: The attendance grows each year. The increase in the number of outstanding guest speakers has attracted larger attendance from our state doctors. The quality of papers presented has improved. State doctors should be urged to submit suitable papers for presentation and the bulk of our speakers should be from the state. Encouragement should be given to the small town physicians to write papers for the state meetings. There is plenty of talent available.

The question arises as to places for the state meetings to be held. The hotel situation in Macon and Augusta is bad. Conferences should be held with representatives from those cities before determining the site of the next meeting. If the Macon and Augusta doctors do not think they can handle the sessions then inevitably we will have to call on Atlanta to be our hosts two to three years in sequence with Savannah relieving her big sister every three to four years. Let's hope Bibb and Richmond counties can do something about it as some of our finest meetings have been held in those hospitable communities.

5—The American Medical Educational Fund: This fund continues to shower monies upon our two medical schools with very little in return. The response from individual doctors to this campaign has been disappointingly poor. Shall we again donate ten thousand dollars from our treasury to this worthy cause? It is your president's opinion that we should, provided our budget committee feels we can do so. This matter deserves very careful consideration.

6—Council: The Councilors have done a great deal of good work during the past year. There is much to be done. There are many practicing doctors who are qualified to become members of county societies but who do not participate in organized medicine. Each councilor should acquaint himself with such physicians in his district and should personally contact each of them and make every effort to have them join some county society, so that they would become members of the state organization. A few more members would give us a third delegate to the American Medical Association. The councilor should meet with and advise the county officers in his district and should assist in every possible way in promoting good district meetings. He should attend all meetings of council and should encourage the vice-councilor to do likewise.

Your president strongly recommends that additional councilors and vice-councilors should be provided for to represent county societies which have one hundred or more members. These additional officers to devote their time to these large societies with the other district councilor and vice-councilor attending to the needs of the more rural sections of the district.

7—Committees: Most of the committees need more activity. Members appointed to committees should take pride in their appointment because they would not be selected if the president did not think them peculiarly fitted for such work. The chairmen should hold more frequent meetings and get the business they were appointed for done as quickly and as thoroughly as possible.

8—House of Delegates: The meeting in Savannah inaugurates a new era with a speaker of the House. This should make for better and quicker legislation and for more prompt transaction of the necessary business of the body. It will certainly free the president from a great deal of work and allow him more time for other important matters.

9—The Woman's Auxiliary: This great organization has grown a great deal this year and has been an enthusiastic backer of the state officers. We have worked in close cooperation and this should be the case in the future.

10—Medical Education Board: The legislature passed the bill authorizing grants and loans to worthy medical students who will agree to practice in rural communities. The Governor signed the bill and the Board was sworn in at the Capitol. The organization meeting was held in Atlanta with your president attending. Many applications have been received and a meeting of the Board will be held in Atlanta on July 1st to process these applications. This is a most desirable culmination of long time efforts of our Association and will eventually bring adequate medical help to the many communities now in such sore need of doctors.

11—Remuneration of the President: It is recommended that a flat one thousand dollars be allotted to reimburse the president each year with no stipulations. If he does his job well he will spend more than that sum and it is quite a chore to attempt any kind of record of such expenditures.

This president, due to extensive traveling by train, plane and automobile has expended considerably more than one thousand dollars. If necessary this can be itemized but he will gripe like heck if he has to do so.

The President's Report was referred to Reference Committee No. 1.

REPORT OF SECRETARY

David Henry Poer

Beginning this year, many details ordinarily contained in this report will be found, for the first time, in that of the Executive Secretary. Perhaps this openly indicates the transfer of all administrative matters of the Association to this officer, rather than by a physician devoting part-time to such duties. This has become necessary because of the marked increase in the volume

of business of the organization, and because of the serious nature of many matters that closely relate to the future of the practice of medicine by all members of the Association.

With the increased activity of this office, it is interesting to note the same for all officers. All Council meetings have been well attended with all Districts represented at each. Your President and President-Elect have attended many meeting in this office and also district and county society meetings over the state in every month of the year.

As the revitalization of the Association proceeds, a basic need in the organizational set-up becomes apparent, and that is the need for a Board of Trustees or Governors, whose duties shall mainly be that of a planning council and policy maker. Such a Board would be made up of seven members including Past-Presidents who would give advice to the officers, to Council, Executive Secretary and even to the House of Delegates concerning the present and future policies and plans of the Association, meeting at least once annually for this purpose. In particular this Board should give concern to the housing needs of the Association on a long range basis and recommend such farsighted policies as may be necessary.

Council

This body meets three times during the year between Annual Sessions which seems to be adequate. Attendance at these meetings has been satisfactory, but Councilors are now confronted with the need for more activity within each district. In particular, it is desirable for county societies to be visited at least once during the year, and active assistance given to perfect its organization and arrange worthwhile business and scientific meetings. Also a canvass needs to be made of all eligible and desirable physicians in each county to bring into membership that large number who up to now has not enrolled.

District Societies

Your other officers will report on the very encouraging activity of all District Societies as evidenced by improved attendance and interest in the semi-annual meetings. Programs are better planned well in advance so that notices can be sent out in ample time to insure good crowds.

County Societies

While progress has been made on a district level, this office can report no such good news in our relations with county societies. This, of course, is the fault of no one, but is due to our failure in the past to make each component society note its position as a cog in a very big machine; the efficiency of which depends on all cogs moving together in unison. In particular, the larger county societies operate as independent units, and it is likely that the need for a good strong state organization has never been demonstrated to them.

Perhaps some progress was made during the year to improve this situation by staging the first Secretaries Conference at the headquarters offices. Both attendance and interest were encouragingly good, and by repeating this conference each year, it is felt that ultimately all components will be moulded into a well-functioning unit. It is also recommended that all county societies with 100 or more members elect one Councilor and Vice Councilor.

House of Delegates

Many important changes have been made in the organizational set-up of this important body, but it is too early to determine the outcome of these. No doubt, the utilization of a Speaker will expedite the proper handling of parliamentary procedure. Likewise, increase in the number of delegates insures more active and intelligent representation of members of the Medical Association of Georgia and thereby needed participation in the solution of the multitude of problems confronting the medical profession today.

Summary

The following recommendations are made for your

consideration:

1. That the program to have all administrative responsibilities of the Association managed by the Executive Secretary and his staff be continued and carried through to successful fruition.

2. That a Board of Governors (or Trustees) be set up to formulate policies and recommend plans for the future of the Association. In particular this Board shall study and make recommendations concerning the housing needs of the headquarters offices of the Association.

3. That the Secretaries Conference be repeated annually, and that the program be arranged by a committee of county and district medical society officers.

4. That the larger county medical societies (100 or more members) elect a Councilor and Vice Councilor to serve their interests in Council.

5. That all committees be urged to serve actively, and make recommendations annually or more often if necessity requires.

The Report was referred to Reference Committee No. 2.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Sid Wrightsman, Jr.

Your executive secretary is of the opinion that a critical and searching analysis of the activities of your Association for the past year will reveal a commendable advancement for the cause of organized medicine in Georgia, alone made possible by the splendid cooperation of Association officers, Councilors and members, alike.

Actually, your executive secretary's major objective during the past year has been to revitalize the role of your headquarters office from one of a passive money-record clearing-house nature to an active agency, instrumental in transaction of membership affairs. Necessarily long-range, attainment of such objective has been and will continue to be contingent on selling to the membership the available services offered it by your Association headquarters office.

A careful review of your annual committee reports, submitted to the House of Delegates by the various chairmen, will indicate the ever-increasing activity assumed by committees. Furthermore, your executive secretary is happy to report that, in accordance with action taken by the House of Delegates at the 1952 Annual Session, the following special committees were appointed by your President and are serving a much-needed purpose: Blood Banks, Veterans Affairs, Hospitals, and Chronic Illness. Especial commendation is due Chairman James C. Thoroughman of the Committee on Blood Banks for the Herculean task pertaining to this aspect in the State which he undertook and accomplished (refer Report). The recently-appointed Subcommittee on Hospitals, an adjunct to the Committee on Public Health and under Chairmanship of Dr. R. F. Spanjer, is also deserving of much commendation.

Membership

Association membership tabulation for the year 1952, below-noted by District, serves as a good indication of increased interest in organized medicine by physicians throughout Georgia. Comparative figures for 1951 and 1952 of AMA dues-paying members evidences a sizable increase for the year just passed. Nevertheless, increased effort in this respect on the part of Councilors and District-County Society officers will be necessary to regain the Association's official apportionment of three AMA Delegates in the House of Delegates of the American Medical Association.

Membership By Districts

Districts	MEMBERS DEC. 31, 1952		MEMBERS DEC. 31, 1951	
	MAG	AMA	MAG	AMA
First.....	189	162	196	147
Second.....	158	99	166	97
Third.....	168	142	175	142
Fourth.....	139	103	141	106
Fifth.....	841	629	787	575
Sixth.....	186	154	189	133

Seventh.....	203	144	191	136
Eighth.....	145	120	144	107
Ninth.....	115	82	107	73
Tenth.....	252	206	256	185
	2,396	1,841	2,352	1,701

First Annual District-County Society Officers Conference

In order to inform members about services made available to them by the Association headquarters office, the First Annual County-District Officers Conference was held in Atlanta on February 22, 1953. The program, which included appearances by Dr. Cyrus Maxwell and Mr. Thomas Hendricks of the AMA Washington and Chicago offices, respectively, was excellently attended by interested physician-members and Auxiliary members and may be continued, with all program arrangements to be worked-out by a special committee comprised of both county and district officers.

Physicians Placement Service

Most members are aware that your Association has been maintaining a Physician Placement Service which, in the past year, has been directly responsible for placing 23 physicians in rural communities in dire need of medical service. Your headquarters office has every intention of expanding this Service in the year to come, serving physicians interested in locating or relocating in Georgia, as well as the communities calling upon it for physicians.

Personnel

Now employed in the headquarters office are Miss Thelma Franklin, bookkeeping and membership record department; Miss Margaret Meadows, stenographer and receptionist; and Mrs. Myrtice Mulligan, assistant stenographer and receptionist. For their faithful and willing service, your executive secretary would like to extend heartfelt gratitude. Our members may feel assured that each commendably serves the cause of organized medicine in all phases of headquarters office activity. Mr. Milton Krueger, Journal Director, continues to improve your official publication, and for which the Association has received unstinting praise from other state medical societies.

The Georgia Plan

Outstanding liaison between your executive secretary and the Insurance Board has been effectuated and stabilized during the past year. All new members of your Association are now forwarded a letter of welcome from the headquarters office, explaining the Association-approved Georgia Plan and soliciting their cooperation in becoming "participating" Plan members. In nine out of 10 cases, the participation pledge cards have been returned, sizably increasing the number of Association members who directly cooperate with commercial underwriters of the Georgia Plan and the public covered by them. This policy will be continued.

Woman's Auxiliary

Your executive secretary has recognized the potential assistance afforded the Association and its public service activities by the Auxiliary, and has sought in all respects to cooperate with its state officers. Facilities in the headquarters office have been made available at all times to Auxiliary members and, as a result, liaison with the Association membership has now been strengthened as never before.

In conclusion, your executive secretary would like to express his profound gratitude to President Holton and Secretary Poer for their personal and unfailing assistance throughout the past year. In addition, he extends enthusiastic thanks to each Councilor, Vice-Councilor, and all county-district society officers for their generous cooperation and frequent hospitality extended him.

The Report was referred to Reference Committee No. 3.

REPORT OF THE TREASURER

David Henry Poer

The audit of the finances of the Association was completed

by a representative of Ernst and Ernst showing the balances as of March 31, 1953. These have been compared to the preceding year and the following significant figures are present:

Cash balance (General Fund) March 31, 1953	\$33,740.83
Cash balance (General Fund) March 31, 1952	52,773.23
Pension and Building Fund March 31, 1953	63,320.00
Pension and Building Fund March 31, 1952	63,320.00
Abner W. Calhoun Lectureship Fund March 31, 1953	226.63
Abner W. Calhoun Lectureship Fund March 31, 1952	202.44

Income from all sources during the fiscal year ending March 31, 1953 was \$29,889.21. This represents a decrease in revenue which has been attributed to the following factors: (a) drop in paid membership of approximately 300, (b) increased number of life memberships (170), (c) decrease in revenues from exhibitors at Annual Session.

The Audit and Appropriations Committee of Council has met with the auditors and has made its recommendations for a budget to Council. This report will be submitted to you directly by the Chairman of Council.

The Report was referred to Reference Committee No. 1.

REPORT OF COUNCIL CHAIRMAN
H. Dawson Allen

During the year the Council has met at the regular scheduled times. In addition, the Executive Committee has met on four occasions including two telephone conference meetings which we have found to be of considerable convenience and less expense to the Association.

All business transacted at these meetings is included in the minutes which have been published in the following issues of the *Journal*:

Council	Executive Committee
September, 1952, Page 419.	June, 1952, Page 270.
November, 1952, Page 508.	January, 1953, Page 25.
February, 1953, Page 101.	March, 1953, Page 153.

These include all meetings of Council except a telephone conference held on April 28 at which time final approval was given to the plans made by the Savannah Committee on Arrangements for the Annual Session and the Session held this morning. This included the expenses of the social hour to be held at 6 o'clock at the General Oglethorpe Hotel for officers, delegates, guests and their wives.

Attendance at all meetings of Council is listed below:

	June 22 1952	October 5 1952	January 11 1953
<i>Councilors:</i>			
Dr. Lee Howard	0	x	x
Dr. George R. Dillinger	x	x	x
Dr. W. G. Elliott	x	x	x
Dr. J. W. Chambers	x	x	x
Dr. Marion C. Pruitt	x	x	x
Dr. H. Dawson Allen	x	x	x
Dr. D. Lloyd Wood	x	x	x
Dr. Sage Harper	x	x	x
Dr. W. Bruce Schaefer	x	0	x
Dr. H. L. Cheves	x	x	0
(Note only three absences during year.)			
<i>Vice-Councilors:</i>			
Dr. Charles T. Brown	x	0	0
Dr. Carl S. Pittman, Sr.	x	x	0
Dr. Guy J. Dillard	0	0	0
Dr. Clarence B. Palmer	x	x	x
Dr. John W. Turner	0	0	x
Dr. H. G. Weaver	0	0	0
Dr. M. M. Hagood	0	0	0
Dr. J. A. Leaphart	0	0	0
Dr. Charles R. Andrews, Jr. ..	0	x	0
Dr. J. Victor Roule	0	0	0

x—Present
0—Absent

(Note: Only two Vice-Councilors attended as many as two meetings and five attended none at all.)

District Societies are requested to nominate only those members who will participate actively in the management of the business of the Association. On the other hand since they have no vote, some members feel that this office has no real function and should be abolished.

Attendance of Executive Comimittee meetings was 100 per cent at all meetings.

A recommendation has been made by the President that the larger county societies with more than 100 members be entitled to one representative in Council. This would certainly give our larger societies more equitable representation and participation in the affairs of the Association.

The final meeting of Council was held this morning at nine o'clock. At that time the report of the Audit and Appropriations Committee was made, which includes the budget for the coming year.

The report of the Council Audit and Appropriations Committee, together with the proposed 1953-54 Budget follows:

Dr. H. D. Allen
Chairman of Council
Medical Association of Georgia
875 West Peachtree Street
Atlanta, Georgia

May 1, 1953

Dear Dr. Allen:

Submitted herewith is the proposed budget for the year 1953-54 as developed by the Committee on Audit and Appropriation. We have carefully gone over this budget item by item and as you will note, if adopted, will show a deficit for the coming year of \$14,920.32.

After careful study of the annual audit, this Committee is cognizant of a deficit for the year 1952-53. This Committee in anticipating the revenues of the Association for the present fiscal year estimated its revenue at \$63,350.00. Its actual revenue was \$61,714.20 and this slight difference was occasioned by primarily the loss of income from dues. In our present Constitution and By-Laws provision is made for Life Members which will reduce the dues paying members to some extent. The major item noted in the audit for the deficit for 1952-53 was an appropriation of ten thousand dollars which was made by the House of Delegates after the budget for 1952-53 had been approved by that body. Your Committee does not feel that the proposed budget for 1953-54 can be trimmed to any greater extent than has been done without considerable loss in services and efficiency of the Medical Association of Georgia.

It is the recommendation of the Committee on Audit and Appropriations that the proposed budget be adopted and that dues for this Association be raised immediately on recommendation of Council to a minimum of \$25.00 per year. In addition it is recommended by this Committee that the appropriation of ten thousand dollars to the American Medical Education Foundation *not* be made for this year unless some other means for these funds be found by Council and the House of Delegates rather than out of operating funds. It is further recommended by this committee that the appropriation for the Better Health Council of Georgia be kept at one thousand dollars for the present fiscal year. This Committee by no means is attempting to deny that the request from the Better Health Council of Georgia for \$2,500.00 is not valid or just, but we do not feel that further deficit financing at this time is wise. It is further recommended to Council that by a motion it designate that income from the building and benevolent funds be carried in the general funds of this Association since at the present time we are paying out in benevolent funds approximately eighteen hundred dollars annually.

It is further recommended that Council and the House of Delegates give serious thought to the meeting place for the annual meeting of this Association for the immediate future since income from exhibitors for 1953-54, you will note, dropped from \$9,000 the present fiscal year to \$5,480 for the next fiscal year.

This Committee would like to take this opportunity to thank Miss Franklin and Mr. Wrightsman of the Headquarters Staff for their time and cooperation in the preparation of this material.

Respectfully submitted,

H. L. CHEVES, M. D.
MARION C. PRUITT, M.D.
J. W. CHAMBERS, M.D., Chairman
Audit and Appropriations Committee

REPORT OF COMMITTEE ON AUDIT AND APPROPRIATIONS PROPOSED BUDGET 1953-1954

Income

Income from Dues	\$18,480.00
Journal Subscriptions	9,240.00
Journal Advertising	18,612.00
Fees from Exhibitors	5,480.00
Interest on Securities	1,478.00
Services from AMA	474.78

Total Income\$53,764.78

Disbursements

1. <i>Salaries</i>		
Dr. Poer	\$ 3,000.00	
Mr. Wrightsman	6,000.00	
Mr. Krueger	5,400.00	
Miss Franklin	3,600.00	
Miss Meadows	2,700.00	
Mrs. Mulligan	2,400.00	23,100.00
2. <i>Fixed Allotments</i>		
Pension Payments	1,800.00	
Honorarium for President	1,000.00	
Attorneys Retainer Fee	1,000.00	
Annual Audit	625.00	
Contribution to Fulton County Medical Society	1,200.00	
Insurance and Bonds for Personnel	150.00	
Medical Auxiliary	600.00	
Better Health Council	1,000.00	7,375.00
3. <i>Journal</i>		
Publication	21,000.00	
Less Headquarters Portion	-900.00	20,100.00
4. <i>Headquarters Expense</i>		
Travel	3,000.00	
Meetings	550.10	
Stationery and Printing	2,000.00	
Postage	800.00	
Telephone and Telegraph	1,000.00	
Depreciation	325.00	
Office Supplies and Expense	475.00	
Dues and Subscriptions	250.00	
Janitor Service	260.00	
Pay Roll Tax	200.00	
Mailing Service		
Prepayment Med. Care Plan	100.00	
Expense of Journal	900.00	
Sundry	300.00	10,160.10
5. <i>Annual Meeting</i>		
Expense		5,00.00
6. <i>Committee Expense</i>		
Rural Health	300.00	
Legislation	1,000.00	
Prepayment Med. Care	500.00	
American Med. Educ. Foundation	150.00	
Medical Defense	500.00	2,450.00
7. <i>New Equipment</i>		
Desk, Chairs and Typewriter		500.00
8. <i>Miscellaneous Expense</i>		
Total Disbursements	\$68,685.10	
Excess of Disbursements over Income	\$14,920.32	

The Report was referred to Reference Committee No. 1.

REPORT OF EDITOR OF THE JOURNAL OF THE MAG David Henry Poer

Shortly after the beginning of this business year, we were fortunate in securing the services of Mr. Milton D. Krueger as Managing Editor of the *Journal*. His report will cover the business details of this publication, but a few extra comments might be added.

The Editorial Board has been increased to include representatives of many specialties and it is planned to continue this program until a well-rounded staff is functioning.

The addition of an Editor to take care of book reviews, photography and illustration, and pharmacology (new drugs) has added much value and interest to our publication.

The many changes in format, styling and copy have been well received and others will be carried as needed.

REPORT OF THE MANAGING EDITOR OF THE JOURNAL OF THE MAG

Mr. Milton D. Krueger

This annual report on the present status of the *Journal of The Medical Association of Georgia* includes four main topics concerning the policies and program of the staff of the *Journal*. The magazine has undergone many basic changes in the past year and the editor and his staff submit this report for your approval.

Staff and Policy

To more effectively edit and improve the *Journal*, several staff appointments were made. A Book Review Editor, Pharmacology Consultant and a Photographic Editor were added to the staff to better handle their respective sections of the *Journal*. The Contributors and Editorial Board were enlarged to represent all areas of the state and staff meetings were called at least twice yearly. A statement of general editorial policy was written, voted on and approved and is now carried in the "masthead" of the *Journal*. A medical editing service was instituted for members of the Association desiring help in the writing or rewrite of a scientific paper.

A program of carrying in the *Journal* each month standing feature pages was instituted to insure a wider and more varied medical coverage. These pages now appear in the front of the *Journal* under the headlines: "On The Bookshelf," "AMEF Page," "In the Editor's Mail," "On the Bulletin Board," "About Our Contributors," "President's Page," "New Drugs Page," etc.

Content

To consider the overall contents of the *Journal* is to ask the members of the Association just what they want in each *Journal*. Judging by the response from the membership and the wise counsel of the *Journal* editorial board, a new program of content was initiated. This included the feature pages published on a monthly basis handled by the staff. It also encompassed a policy of carrying more editorials—stimulating members of the editorial board to submit not only their own contribution, but to also get Association members in their areas to contribute to the *Journal*. And along with this, members of the *Journal* board were given the responsibility of stimulating the writing of more scientific articles in their areas.

Members of the editorial board were also given the duty of screening scientific papers on merit and worthiness for publication. Every paper submitted for publication is now reviewed by at least two members of the board, and in the case of "dubious" papers, at least three members pass judgment on its merit.

Special articles were sought and the response has been excellent, mainly due to the activity of the board. The News and Information section of the *Journal* has been narrowed in scope and expanded in specific coverage of personal items concerning Association members.

In The Association section of the *Journal*, the staff has scrupulously followed the policy of making all Association business a matter of record by publishing it in the form of reports, etc. The staff feels members are well informed and up to date on all Association activity.

Typography and Format

Perhaps some of the most striking changes in the *Journal* have been those of "looks," more commonly called format. The board approved a new cover design with a photograph each month to enhance Association members' interest. Readability and simplicity in departmentalization has been planned for by redesigning the contents page, and so organizing the contents to fall in six main categories.

Typographical changes from a "dull, stuffy looking"

grey mass of print into a modern vehicle of appetizingly displayed printed material include: excessive use of white space and large headline type; use of a different text type for subheads to break grey masses of print; variation of headline type on feature pages to separate them from other sections; use of sketches to brighten display; use of "filler material" to brighten otherwise endless columns of grey printed matter; etc.

While the typography of the *Journal* has been in the experimental stage during the past year, the staff now feels that the present format is acceptable and suits the publication's many purposes—but the staff also feels that graphic presentation must not be static, and must be amended and changed from time to time to keep up with the trend of "today" in magazine publication.

Financial Status

It is the policy of the *Journal* to attempt to "break even" in its annual budget. Some few journals have accrued a profit from their publication, but the large majority of medical journals are annually "in the red," depending on a subsidy from their parent Association. After consideration of the board, it was hoped that the *Journal* would pay for itself. At this time an audit is underway and upon its completion, a full financial report will be added to this report.

The Report was referred to Reference Committee No. 4.

FIRST DISTRICT COUNCILOR REPORT

Lee Howard

I am very glad to report that after remaining dormant and apparently dead for the past 10 years, the First District Medical Society came to full life the afternoon of March 18th, at Statesboro, Ga. Every active society in the district was well represented by both doctors and auxiliary members.

At the dinner and entertainment in the evening, there were one hundred and sixteen doctors and wives present, I think possibly the largest attendance for any district society during the past year.

Dr. Charles T. Brown, Vice-Councilor, has been temporarily incapacitated but has now well recovered from a recent gastric resection and he has promised to assist me in visiting all the active societies in the district during the spring and summer.

There is a great need to consolidate some of the smaller county societies into larger active groups on a geographical basis, as there are still several inactive societies having less than three members. This condition is state-wide and I think is of first importance as a project for councilors throughout the state.

Your Councilor for the First District has attended every meeting of the Council during the past year.

The Report was referred to Reference Committee No. 1.

SECOND DISTRICT COUNCILOR REPORT

George R. Dillinger

The Second District had a good year during 1952. Both the spring and fall meetings of the District Society were well attended and there were excellent scientific programs.

The Dougherty County Medical Society is to be commended for their activities and the excellence of the scientific programs presented. Many physicians from surrounding counties in the District attend their meetings regularly and find their programs of great benefit.

Since the adoption of a new Constitution and By-Laws by the Thomas County Medical Society, the society is now functioning well. The Scientific Programs have been outstanding and well attended.

The Auxiliary has been active in the Second District and in most of the counties is well organized. It is hoped that before the end of 1953 every county will be organized and that important work be further increased.

The Second District lost eight members in 1952, compared to the 1951 membership roster. Part of the loss

may be accounted for by death and change in residence, but part is also due to inactivity and lack of interest in the local County Medical Societies. Too many members of the Medical Association of Georgia are not paying dues to the American Medical Association. This has resulted in the loss of a Delegate in that parent body.

Consolidation of some of the smaller County Societies in the Second District would increase the efficiency of the local organizations, and enable them to have much better scientific programs.

The Report was referred to Reference Committee No. 2.

THIRD DISTRICT COUNCILOR REPORT

W. G. Elliott

There are 12 organized Medical Societies in the Third District. One of them, Turner County, has only one member and he is an honorary member or life member and he does not wish to join another Society. The other doctors in that County belong to other adjoining Societies. Macon County has only two members who pay their dues from that Society and one life member. Other members in that County belong to Sumter County Society. Houston-Peach Society has only three members, several doctors in this county belong to the Bibb County Society. The Ocmulgee Society seems to be somewhat split up and I have been unable to get any information about the cause and remedy. The largest Society in the District, Muscogee, is very active and they have very good monthly meetings, and have some outstanding speakers all along. I have attended several of these meetings. At present there are 83 active members, three on leave of absence and six life members. The Sumter County Society is very active and they have had some very good programs. The Randolph-Terrell Society is active and meets monthly, but we have a rough time getting a good attendance. Several of the other Societies have very little activity except dues paying.

As of December 31, 1952, there were 169 members in the Third District who had paid Medical Association of Georgia dues and 142 who had paid American Medical Association dues. This was six less than 1951, for the Medical Association of Georgia dues and the same for the American Medical Association.

There were two district society meetings during the year. The June meeting in Parrott, Georgia, honored Dr. John Arnold, who has been practicing medicine well over 50 years, and he always has been very active in the Third District affairs. The fall meeting was held in Americus and a very good scientific program was presented. There was fair attendance at these meetings.

During the year a cancer symposium was held in Columbus, and a chapter meeting of the Georgia Chapter of American College of Surgeons, also held in Columbus. All doctors in the District were invited to these meetings and many attended.

The Report was referred to Reference Committee No. 3.

FOURTH DISTRICT COUNCILOR REPORT

J. W. Chambers

The Fourth District has quarterly meetings which are usually well attended and interesting scientific programs were provided. Frequently, members of the Fourth District invited outside speakers for meetings.

We are continuing our efforts to work out a consolidation of the small counties with some of the larger counties in order to improve our organizational structure. One county society reorganization particularly in question is the possible merger of Rockdale and Newton Counties, and it is under way at the present time.

The interest of the profession in general throughout the Fourth District for this year has been quite good. There is now functioning a district-wide Selective Service Advisory Committee of which I am Chairman.

Dr. Palmer, the Vice Councilor, has been extremely helpful in carrying on activities in the upper part of the district. Between Dr. Palmer and myself, we have

contacted members of every county organization in our district and received whatever help and advice we had sought.

In general, I would say that our activities in the Fourth District have been somewhat improved over the past year, and we continue to look forward to even greater stimulation of interest.

Counties and Secretaries	Members December 31, 1952		Members December 31, 1951	
	MAG	AMA	MAG	AMA
Clayton-Fayette	6	4	5	3
R. P. Campbell, Cedartown				
Coweta	19	---	19	---
William P. Smith, Jr., Newnan				
Henry	0	---	3	2
G. R. Foster, Jr., McDonough				
Lamar	6	6	5	5
S. B. Traylor, Barnesville				
Meriwether-Harris	15	11	15	13
R. B. Gilbert, Greenville				
Newton	8	7	9	7
C. B. Palmer, Covington				
Spalding	34	21	23	21
J. E. Clouse, Jr., Griffin				
Troup	42	38	42	37
Curran Easley, Jr., LaGrange				
Upson	19	16	20	18
Total	139	103	141	106

The Report was referred to Reference Committee No. 4.

FIFTH DISTRICT COUNCILOR REPORT

Marion C. Pruitt

During the year there has been much favorable activity in the County and District Medical Societies. The District showed 841 members of the Medical Association of Georgia of which 627 are members of the AMA. In 1951 there were 787 members of the Medical Association of Georgia and 575 members of the AMA. This shows an increase of 54 members for the Medical Association of Georgia and 52 for the AMA.

The credit for the work in the District has not been to any one individual but to all the officers of the County and District Societies and the Woman's Auxiliary.

There is a feeling of fellowship and progressive attitude among the members of the District as well as the increase in growth.

The Report was referred to Reference Committee No. 1.

SIXTH DISTRICT COUNCILOR REPORT

H. D. Allen, Jr.

The two regular district meetings have been held since the 1952 annual meeting of the Medical Association.

The summer meeting was held in Milledgeville, Ga., in the midst of an extreme heat wave. There was an excellent attendance, and an excellent scientific program was given by the visiting consultant staff of the Milledgeville State Hospital.

Mr. Sid Wrightsman, Jr., the executive secretary of the Medical Association of Georgia, also attended this meeting, representing the officials of the State Association.

It was decided at this meeting that the summer and fall meetings would be changed from the third Thursday in June and the second Wednesday in December to an unfixed date, this date to be determined from meeting to meeting so as to avoid the extreme summer heat of June and to avoid the rush of the beginning Christmas season in December. This was left in the hands of a committee to determine more suitable dates for meetings.

The December meeting was held in Macon, with a

scientific program put on by the local members with several excellent papers. Officers were elected at this meeting.

The last report of the census of membership by counties showed the usual number of members with only a few variations, caused by deaths or removals from the district. The variations in membership in Baldwin County and Laurens County is due to the rather large turnover in the staff of the Milledgeville State Hospital and the Veterans Administration Hospital of Dublin, Georgia.

Councilor Allen, in amending his printed report, submitted the following addendum:

You may add to my report that Hancock, Baldwin, and Bibb Counties are already combined. Washington, Laurens, Baldwin, and Bibb County are having regular monthly meetings except where they are suspended on account of conflict with other medical meetings, and Baldwin, Laurens, and Washington suspend meetings during the three summer months. Monroe County and Jasper County could easily combine with Bibb.

I believe that the two Doctors Dupree, in Gordon, Ga., Wilkinson County, are already members of the Bibb County Society, and I believe Bibb County has membership from Houston and Peach Counties, which are considered in the Sixth District medically, but are not in the Sixth District Congressionally.

The Report was referred to Reference Committee No. 2.

SEVENTH DISTRICT COUNCILOR REPORT

D. Lloyd Wood

The Seventh District annually holds two District Society meetings. These meetings being afternoon and early evening sessions. Generally four scientific papers are given, most of these papers given by men of our District. Of late years there has been a distinct improvement in the quality of the papers denoting the high medical services being rendered by the doctors of the Seventh District as a whole. The fellowship enjoyed and the cooperation between the doctors in every component Society seems to be very high.

Several new hospitals have been built in recent years and others are now in the planning or pre-building stages.

An accurate total of members of the Societies is not available at the present time but from all indications will be larger than in 1952. The number of non-members in the District is very low.

The Report was referred to Reference Committee No. 3.

EIGHTH DISTRICT COUNCILOR REPORT

Sage Harper

The regular one-day meeting of the Eighth District Medical Society was held at Brunswick (St. Simons Island) October 14, 1952. The meeting was fairly well attended by representatives from Ware and Glynn County Societies—but none other except one from Coffee. The Councilor made a report of MAG activities since the Annual State Convention. Suggestions as to instructions for wishes of the District to be carried out by Councilor were requested. There were none.

There will be (was) a regular Spring meeting of the Society in Valdosta April 14, 1953.

With the exception of the Ware County Society, there is very little County Society activity. South Georgia Society is progressing fairly well, but all others have plenty of room for improvement.

There is one more member in the Eighth District Society than in 1951. 1953 should show more increase. The total for 1952 was 145.

Membership in the AMA seems to be increasing slowly.

Recommendations

1. More work by the Councilor, District and County Officers—and more effort and interest by the members of each Society.

- 2. Closer liaison between the County Societies and the Councilor.
 - 3. Better attendance at District Society meetings—especially by Delegates to the State Convention.
- The Report was referred to Reference Committee No. 4.*

NINTH DISTRICT COUNCILOR REPORT
W. Bruce Schaefer

The situation in the Ninth District in every respect has been commendable during this past year. Members have been cooperative, and comparative membership figures (below noted) indicate increased interest in "organized medicine" on behalf of the physicians in this area.

	MAG Members Dec. 31, 1952		AMA Members Dec. 31, 1951	
Banks	1	1	1	1
Blue Ridge	10	9	9	7
Thomas J. Hicks, McCaysville				
Cherokee-Pickens	11	7	12	6
Arthur M. Hendrix, Canton				
Forsyth	5	4	4	2
J. S. Mashburn, Cumming				
Gwinett	10	3	10	3
Harry Hutchins, Buford				
Habersham	15	10	14	11
L. G. Hicks, Jr., Clarkesville				
Hall	33	26	29	21
Martin H. Smith, Gainesville				
Jackson-Barrow	16	11	15	13
Lewis W. Moore, Winder				
Rabun	3	3	2	1
J. C. Dover, Clayton				
Stephens	11	8	11	8
C. L. Ayers, Toccoa				
Total	115	82	107	73

The Report was referred to Reference Committee No. 1.

TENTH DISTRICT COUNCILOR REPORT
H. L. Cheves

The Tenth District had two excellent meetings which were well attended. The winter meeting being in Athens and the summer meeting in Elberton.

It has been my desire to have only five County Medical Societies in this district. We have too many small ones which cannot function profitably. My recommendation is the following: one in each of the following places, Augusta, Athens, Washington, Elberton and Monroe.

Membership has not increased and I feel that larger Societies might make for increased interest. Eighty per cent (80%) are A.M.A. members.

I would like to suggest that each county society inform its Councilor of time and place of its meeting. He may not be able to attend all but will certainly attend more during the year.

One grievance case has been settled in this district. Both patient and doctor are now happy.

Below is a report of membership in detail.

	MAG Members Dec. 31, 1952		AMA Members Dec. 31, 1951	
Clarke-Madison-Oconee	42	34	40	33
J. Bothwell Traylor, Athens				
Columbia	2	1	2	0
Elbert	15	10	14	9
M. H. Arnold, Elberton				
Franklin	6	3	7	3
E. T. Poole, Lavonia				
Greene	2	2	2	3
F. H. Killam, Greensboro				
Hart	4	4	4	3
Louis G. Cacchioli, Hartwell				
McDuffie	5	5	1	1
B. F. Riley, Jr., Thomson				

Morgan	5	2	5	2
W. C. McGeary, Madison				
Richmond	147	128	153	117
W. K. Philpot, Augusta				
Walton	8	8	8	8
Harry B. Nunnally, Monroe				
Warren	2	2	3	2
A. W. Davis, Warrenton				
Wilkes	14	7	16	4
M. C. Adair, Washington				
Total	252	206	256	185

The Report was referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON SCIENTIFIC WORK
Thomas L. Ross, Jr.

Chairman Thomas L. Ross, Jr., of the Committee on Scientific Work submitted the 103rd Annual Session printed program as the annual report of his Committee.

The Report was referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON LEGISLATION
Spencer A. Kirkland, Chairman

It would be difficult to report on all of the Bills introduced during the 83rd Congress in Washington.

During the first week of the Session about twenty-five hundred Bills of various kinds were introduced. Several hundred of these Bills were Medical Bills or touched on the Medical Profession.

The Committee on Legislation does try to follow through all the Medical proposals and aid in passing all constructive Bills as well as help to defeat the destructive measures.

The Medical Profession was extremely proud when General Eisenhower during his campaign, repeatedly stated his opposition to any National Compulsory Health Insurance or Socialized Medicine in any form. On this matter, I understand he is supported all the way by the Republican Party's Platform.

In contrast, President Truman consistently advocated Compulsory Health Insurance. This does not mean the end of the issue, but it is a safe assumption that we can rest easier.

The International Labor Organization, which is the greatest threat to Organized Medicine, began in 1949, in conjunction with the League of Nations and was hooked up later with the United Nations.

At their meeting in Geneva last year Minimum Standards of Social Security in nine fields was discussed and approved. Fifty-nine Nations sent Representatives to this Convention. Each Nation had two Representatives.

The Medical Care Field is one of their worst threats to Organized Medicine.

In Washington, a resolution has been proposed by Sen. Bricker of Rhode Island, which calls for a Constitutional Amendment banning Treaties and executive Agreements that would abridge any domestic rights of American Citizens.

Senator Bricker singled out the International Labor Organization as among the United Nations Agencies working on Treaties affecting American Citizens. The Senator commented that the International Labor Organization's modest ambition is to become the Economic Overseer of all humanity. He said that his Bill would make humanitarian Treaties subject to two conditions.

FIRST—No such Treaty would be effective, if it would undermine any Constitutional rights of any American.

SECOND—No such Treaty would be effective if it would entrust the rights of American Citizens to the supervision of International Agencies over which they exercise no control.

If I should try to give you even a brief outline of only a few of the most interesting Bills in Washington, this Report would be too lengthy and tiresome, so I will pass on to the Local Bills in the Georgia Legislature.

Bills Passed by the Senate and House

(1)—H.B. 59—Which limits Professional License Taxes by Counties or Municipalities to \$15.00 per year.

(2)—H.B. 197—Provides for issuing Birth Certificates in event of adoption when Foster Parents furnish adoption Certificates and other information.

(3)—H.B. 380—Allows for the employment of more Drug Inspectors to enforce the State Food and Drug Act.

(4)—H.B. 471—Provides uniform system for registration by the Court Clerk in each County of Marriage, Divorce and Annulments.

(5)—H.B. 508—Allows compensation to State Employees infected with Tuberculosis while caring for, or treating a State Patient.

(6)—H.B. 564—Provides for a Municipal or County Hospital contracting with the Local Authorities for the care of the indigent sick and injured people within the City for at least thirty years.

(7)—H.B. 487—Allows the State Crime Laboratory Head and the Director of the Health Department to name Medical Examiners for Autopsies. This Bill does not have the approval of the Committee or the Medical Association of Georgia and should be changed and amended. We possibly can do this at the next session of the Legislature.

(8)—H.B. 614—Provides for free maintenance at the Milledgeville State Hospital for all Georgians.

(9)—S.B. 24—Allows Municipalities and Counties to assess two mills for Hospital improvements.

(10)—S.B. 34—Provides for the licensing of Practical Nurses and requires them to take a State Board Examination.

The Committee, in addition to trying to pass Bills, has to watch the Calendar in the Legislature and try to kill measures which would lower the standards of Medicine.

The Osteopaths tried to get a Bill passed which would have allowed them to practice Medicine like a Physician in the State. After a heated argument, we were able to kill this Bill in the Senate Committee.

The Georgia Assembly adjourned with the Senate Bill No. 30 still in the State of the Republic Committee. This is a good Bill and was drawn in order to give the Joint Secretary more authority in handling non-registered and non-licensed Practitioners. It passed the Senate 33-0.

The Committee on Legislation discussed the bill with numerous men in the House. The Chairman of the State of the Republic Committee, who favored the measure, and members of the Committee informed me that the opposition was very great against this Bill.

The Committee felt that to bring the Bill out of the Committee at this time would mean defeat, so rather than have it defeated, we decided not to try and push this Bill out of the Committee at this time but take it up again in November, by which time we will have had ample time to contact all Members of the State of the Republic Committee as well as all House Members. We feel that we did a wise thing by proceeding in this way at the present time.

The Committee recommends:

FIRST—That all matters pertaining to Medical Legislation be referred to the Committee on Legislation for consideration.

SECOND—That all State publicity articles be cleared through this Committee before being released to the public.

THIRD—That the members of the Medical Association of Georgia continue to give us their whole-hearted support and that they phone or write us any suggestion for the betterment of Medicine from a political standpoint.

In conclusion, the Committee on Legislation wishes to thank the Woman's Auxiliary of the Medical Association of Georgia, the Doctors and other members of the Senate, members of the House, Mr. John Dunaway, our lawyer for the Association and last but not least the Governor of Georgia for the splendid aid given our Committee during the recent Georgia Assembly.

As an addendum to his printed report, Chairman Spencer Kirkland of the Committee on Legislation briefly addressed the House, requesting increased cooperation and assistance in future legislative matters on the part of all members. Vice-Chairman Jack C. Norris of the Committee on Legislation, as an addendum to the Committee's printed report, submitted the following resolution:

"BE IT RESOLVED: That our Legislature and our Governor fully cooperate to the extent that any and all laws pertaining to future medical legislation relative to Georgia medicine be first referred to the Committee on Legislation of the Medical Association of Georgia for consideration, approval or rejection before being enacted into law."

Speaker Goodwin referred the Report, with addenda, to Reference Committee No. 3.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

R. Hugh Wood, Chairman

Following the last committee report of September 25, 1952, this committee has continued to study the question of nursing shortage in the State of Georgia, particularly in the hospitals of the state. The chairman, with an ad hoc committee, met to consider this question with representatives of the Medical College of Georgia, the Georgia State Nurses Association and others. Along with the Georgia State Nurses Association the committee has sponsored a bill concerning the qualifications and licensure of practical nurses in Georgia. Such a bill has now been enacted into law and signed by the Governor.

It has been the sense of this committee and representatives of other agencies with which the committee has conferred that attention should be given to the training of all categories of nurses to serve the health needs of the state. These are: the professional degree program, the registered nurse with the hospital diploma, nurses aides, and practical nurses.

On October 5, 1952 the chairman met with a subcommittee of the Public Health Committee of the Medical Association of Georgia at the Academy of Medicine. Those present were Doctors C. L. Ayers, H. A. Goodwin, W. D. Hazelhurst, Mr. Milton Krueger, Doctors E. M. Lancaster, D. Henry Poer, T. A. Sappington, T. F. Sellers, Ernest Thompson, R. C. Williams, R. Hugh Wood and L. C. Yeargin. We heard an extensive report by Doctor R. C. Williams of the Hospital Division of the State Health Department. He listed 29 new hospitals built by Federal Funds since 1947, under the Hospital Construction Act. Four hospitals had alterations and remodeling under that program, and two had received allocations for equipment. Twelve hospitals were in the process of construction and 10 additional hospitals had been approved. Fifty-five new physicians have located in areas where hospitals have been recently built. There are now a total of 230 hospitals in the state, 80 per cent of which have 50 beds or less.

Dr. Williams pointed out the severe shortage of nurses and other trained personnel to staff these new hospitals. He proposed that this committee sponsor a training program for nurses aides and stated that the State Department of Public Health (Hospital Division) has outlined a course and will assist in the planning of such a program. He also stated that dietitians, hospital administrators, accountants, and medical technologists are available for consultation with hospitals on request to the State Department of Public Health.

Dr. Williams said that a nine-month course of instruction for hospital administrators is offered by the Atlanta Division of the University of Georgia. In view of the shortage of trained administrators for Georgia Hospitals, it seems that this is a promising field for young men. It offers opportunities for useful service and adequate income.

The broad question of the accreditation or approval of hospitals in Georgia was fully discussed by the members present at this joint committee meeting. The question was posed as to whether or not the MAG wants

to sponsor a system of accreditation or approval of the state's hospitals. Of course, no one present was capable of answering this question, but it is passed on for attention by the Association.

Dr. Thomas Sellers, director of the State Department of Public Health, pointed out that the Hospital Division of the Health Department has three functions: (1) the licensure and approval of the physical structure and facilities of hospitals, (2) construction of new hospitals, and (3) the remodeling of existing hospitals under the Hospital Construction Act. This responsibility ends when the hospital is completed and it is turned over to the local authorities. Often these hospitals get into difficulties of one type or another, chiefly due to inadequate staff and inadequate experience in hospital management, and at times have called upon various agencies of the Health Department for help and advice. The State Department of Public Health does not want to go any further in this matter than the medical profession of the state requests and approves. Likewise, this question could not be answered by this joint committee, and it is passed on to the MAG for its further consideration.

The next question discussed was the problem of surgical privileges and categories of staff membership in hospitals. This becomes an acute problem when a new hospital is built in a small town having only three-five doctors. Customarily, of course, the staff of a large hospital recommends the appointment of new members to the staff, after investigation of the physician's training and experience. In the case of the new hospital, there is no one to do this. The question of who bells the cat comes up. The staff of one hospital in a town of Georgia had met the problem in the following way, which seemed effective in their case. This hospital had a staff of 15 physicians, and the question came up as to who should be allowed surgical privileges. It was decided that each physician would operate only when assisted by another physician member of the staff and that they would continue in this way for one year. At the end of this time they would then agree among themselves as to who would be allowed to operate individually, without professional assistance by another staff member. In this way the surgical privileges were granted gradually to successive staff members as competence was established by practice in the hospital. This is recorded as an example of how the problem has been handled in one instance.

Chairman Wood submitted the following communication as an addendum to his printed report:

To: Dr. R. Hugh Wood
From: Dr. Russell H. Oppenheimer

Re: Report on Postgraduate Course for General Practitioners, October 6-10, 1952.

The course this year was received with interest which indicated that it was more successful than any previously offered by the School. This was manifested by consistent attendance and the good general discussions which followed each presentation. The grouping of related subjects by dividing the days of the week advantageous, as did the use of the symposium plan.

Again this year the announcement was sent through Mrs. Roberts' addressing service to all the doctors in Alabama, Florida, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee, in addition to those in Georgia. You will be interested in the following statistics:

Number of Registrants	85
Number from Georgia	39
Number from Other States	46
Alabama	6
Florida	12
Mississippi	3
Tennessee	10
North Carolina	8
Oklahoma	1
South Carolina	6
Age Groups	
25-30	8
31-40	28
41-50	32
51-60	8
61-70	8
71-77	1

SCHOOLS OF GRADUATION

Atlanta Sch. of Med	1	Coll. of Med. Evang.	1
Atl. Coll. of Phys. & Surg.	1	Univ. of Michigan	1
Univ. of Arkansas	3	Univ. of Nashville	1
Univ. of Alabama	1	Northwestern Univ.	2
Birmingham Med. Coll.	1	New York Univ.	2
Duke Univ.	1	Univ. of Pittsburgh	1
Emory Univ.	27	Univ. of Rochester	2
Univ. of Chicago	1	Med. Coll. of State of S. C.	4
Georgetown Univ.	1	Syracuse Univ.	1
Med. Coll. of Georgia	11	Univ. of S. C.	2
Hahnemann Med. Coll.	1	Univ. of Tenn.	5
Jefferson Med. Coll.	1	Tulane Univ.	3
Johns Hopkins	1	Vanderbilt Univ.	2
Univ. of Louisville	1	Med. Coll. of Virginia	3
Univ. of Maryland	1	Washington Univ.	1
Western Reserve Univ.	1		

Questions concerning the manner of conducting postgraduate education were discussed with members of the Academy of General Practice throughout the past year and with the group and individuals attending the course just completed. Factors which need to be considered are:

1. The difficulty general practitioners have of remaining away from their practice for the period of a full week.
2. Greater convenience for them in attending courses no longer than two or three days.
3. Relative value of a short course for those who come from long distances (note areas from which doctors came).
4. Possible advantage of monthly one-day courses each relating to a single field or subject.

Please send your ideas to this office so that they may be used in planning for the coming year.

Very truly yours,

/s/ Russell H. Oppenheimer, M.D.
Professor of Clinical Medicine
Director of Postgraduate Education

The Report, with addendum, was referred to Reference Committee No. 4.

REPORT OF COMMITTEE ON MEDICAL DEFENSE Marion C. Pruitt, Chairman

Chairman Marion Pruitt of the Committee on Medical Defense announced that his annual committee report would duly be presented verbally to the proper reference committee, announced to be Reference Committee No. 1.

REPORT OF COMMITTEE ON PROFESSIONAL CONDUCT

Ralph H. Chaney, Chairman

The Committee on Professional Conduct met in Macon, Georgia and organized itself, making arrangements to meet on call of Chairman should anything arise demanding the attention of Full Committee.

One grievance reached the Chairman but following a request for more full and detailed information nothing further was received and the matter dropped.

The Report was referred to Reference Committee No. 1.

REPORT OF COMMITTEE ON HISTORY AND VITAL STATISTICS

J. Calvin Weaver, Chairman

As chairman of the History Committee of the Medical Association of Georgia I regret having to report that there have been no meetings of this committee during the past year. In fact, so far as I know, nothing has been done towards following up the eventual publication of the medical history of Georgia.

Personally, I have published in the *Journal of the Medical Association of Georgia* a sketch of Dr. E. N. Calhoun who originally lived in Decatur and later moved to Atlanta. Also, during 1952, I did a very complete and thorough research job on "One Hundred Years of Medicine in DeKalb County" in which I covered the years

from the founding of the county in 1822 up to about 1922. This article totaled one hundred eighteen type-written pages and took into consideration nearly one hundred doctors of DeKalb County.

If it were possible it get some members of the Association in each county of Georgia to comb the county for its medical history as carefully and completely as I did DeKalb last year, we would certainly have material for a wonderful state medical history. But that is about the biggest "IF" I can think of. As an illustration, I wrote scores of letters asking cooperation towards compiling a medical history of Georgia and except for three or four who sent me sketches of their lives and practice, I did not even get an answer from all of the others to whom I had written. I wrote to several, asking for information on their fathers' or grandfathers' lives, but no response was forthcoming.

I have now resumed my work on the medical history of Georgia: Georgia as a province, which I had partially done before taking up the DeKalb County project and am hoping to finish this year.

The medical history of Georgia as a State is going to be an immense undertaking and I do not hope to live long enough to see it finished. I wish that more interest could be taken in this medical history, but I am not very hopeful of this ever coming about. As an illustration of this lack of interest and indifference on the part of the doctors on this question of medical history, I was requested by one of the attaches of the Medical Association of Georgia to contact a young doctor in one of our larger counties, who, the attache thought, was interested in getting up the history of his county; as I had one of the old histories of that county, I wrote him and furnished him a list of all of the doctors written up in this history and asked his cooperation in our state history; I never even got a reply to this letter that I wrote him!

By way of *recommendation* (and I have recommended this in writing before) our only hope in getting the medical history of Georgia written lies in appointing one man, who is acutely interested in this subject, as official historian for the Association and let the Association back him up financially towards getting this history written.

The Report was referred to Reference Committee No. 1.

REPORT OF COMMITTEE ON PUBLIC HEALTH

C. L. Ayers, Chairman

Since the last meeting of the State Association this Committee has held two meetings at the Academy of Medicine in Atlanta. In addition to the members of the regular Committee this meeting was also attended by the President, and President-elect of the State Association, also the State Secretary. Dr. T. F. Sellers, Director of the State Health Department, and Dr. R. Hugh Wood, Chairman of the Committee on Medical Education and Hospitals were invited to attend this meeting. In addition to the usual duties of the Committee, it is supposed to be a liaison Committee between the State Association and the State Health Department. Hence Dr. Sellers was asked to give to the Committee any problems that his department might have. After briefly discussing some of the activities of his department, he stated that one of his major problems is at present the proper staffing, and nursing problems of the recently constructed Hill-Burton Hospitals in the State. Dr. Hugh Wood also discussed it from the angle of the Hospital Committee, and said as the newly constructed hospitals are widely distributed over the State, he would appreciate the co-operation of the Committee on Public Health as it is a large Committee composed of one member from each District Society and one from each County Society in the State, and in this way each Committee could get the view point from the State at large. Hence these two Committees have worked jointly during the year. A sub-Committee on Hospitals as a public health problem was appointed with Dr. Raymond F. Spanjer of Cedartown as Chairman. This Committee was to investigate and study hospital problems and report to these two Committees.

In a general way the public health program in the

State has progressed favorably during the past few years and much has been accomplished—many communicable diseases have been almost eliminated and others greatly reduced. But there is still much to be done. Our State Health Department is doing a good job. It is growing and its activities are enlarging each year. Its laboratory service is very helpful to the doctors in general practice. The immunization program is expanding. Sanitary inspections, educational programs, hospital services, rabies control, and many other helpful measures are being extended to the people of Georgia. We should get better acquainted with the facilities offered by them. We need the State Health Department and the Health Department needs the 2000 physicians which comprise the Medical Association of Georgia.

The State Health Department requests for endorsement as follows:

1. Approval and endorsement of legislation to provide for the quarantine of infectious tuberculosis.
2. Approval of the need for prompt and accurate reporting of diseases.
3. The study of ways to provide early and adequate hospitalization of complicated obstetrics.
4. Emphasis on need for continuous health supervision of children.

We feel that these requests are timely and that they will meet the endorsement of the Association.

We feel that most public health problems have been met in a successful manner, but there is one that has not had much concerted attention as yet, namely the growing addiction to the use of narcotic drugs and barbiturates. In the March issue of "Today's Health" published by the AMA it was stated that in 1951, 688,500 pounds of barbiturates were produced.

It is obvious that legitimate medical practice can not use this quantity of any drug, and it is estimated that more than half of this amount is distributed through illegitimate channels for non-medical purposes. An automobile driver under the influence of barbiturates endangers the lives of other people. This is a public health problem. This Committee believes that there should be greater understanding, and better co-ordination of the Georgia Department of Public Health with those engaged in private practice and to that end we would advise that there be held each year at least two meetings between representatives of the Health Department and the Committee on Public Health.

The Report was referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON MATERNAL WELFARE

H. F. Sharpley, Jr., Chairman

1—*Maternal Education Program.* The maternal educational program is well under way. The educational items to be posted above the scrub basins had to be approved in advance of setting the program in motion. Double post cards (reply) were mailed to every superintendent of every hospital within the state of Georgia. This inquiry was necessary to ascertain the number of basins that each hospital possessed on account of the printing.

2—*Committee Posted and a Bead Drawn.* The Georgia Department of Public Health presented the Committee with a very thorough statistical study of the remaining maternal deaths as to cause and distribution. In fact, they went beyond the call of duty and broke down all the maternal deaths for a period of five years by cause for each of the 159 counties of Georgia. In addition, many graphs were shown of other situations, namely, the stillbirth neonatal deaths, the mid-wife situation, etc.

3—*Questionnaire Proposed (From No. 2 above).* The Committee on Maternal Care proposes that a statistical questionnaire be drawn up by the Committee and sent to all physicians inquiring upon the still deaths and deaths of all others infants up to one month after delivery, by the Medical Association of Georgia. Other suggestions co-related are subheaded as follows.

(a)—A small portion of the questionnaire to include some simple questions on the pregnancy and labor.

(b)—That some pediatricians be added to this Committee without enlarging it into an unwieldy size.

(c)—The name of the Committee to be "The Maternal and Infant Care Committee." The word "Infant" to be inserted.

(d)—Checked all possibilities that could be thought of as for the workability of these questionnaires. The death and stillbirth certificates can be pulled by the Bureau of Vital Statistics, etc.

(e)—It may be necessary at the onset that only a subdivision of this large group be included in the initial set up like stillbirths, then gradually add deaths up to five days, etc.

Explanatory Note on Proposal No. 3. Since the maternal rates have undergone a great drop, the question is often asked, when will they reach the bottom (unavoidables)? At the present time, there are too many potential maternal deaths all about that keep feeding here and there the list of maternal deaths. A potential death is one where the prenatal and delivery care is so poor (induction, pituitrin, forceps) that the baby is unnecessarily stillborn and the mother ran a high risk of death. Some here and some there do not survive the risk. The stillborn baby is this Committee's lead to the situation whereto education needs distributing.

Some other state committees are adding "police action" to the old maternal questionnaires which do not reach these potentials and with the maternal death list down, this distribution of forceful maternal education is slow.

This set-up is new and should be ideal for years to come. Its distribution of education is wide and also no antagonism is created by criticism.

4—*Hospitalization.* Study the need for and implement increased availability and accessibility of early and adequate hospitalization for complicated obstetrics.

5—*Midwives.* Enthusiastically endorses the promotion of sorely needed legislation for the regulation of the practice of midwifery in Georgia. Some midwives (with aid) are jumping the gun on the present regulations. Apparently the Georgia Department of Public Health is in need of help by the Medical Association of Georgia. Possibly this situation should be studied by both the Legislature and Public Health Committee of the Medical Association of Georgia or by a new special Committee thereof, appointed by the President. In the meantime, renewed support should be given the local health departments.

6—The endorsement of the establishment in Georgia of a school for graduate nurses in obstetrics was tabled through the lack of information.

7—"All My Babies." A film by the Georgia Department of Public Health was shown initially on January 21, 1953 in Atlanta. Dr. E. D. Colvin, the Vice-Chairman of this Committee attended the preview. This film is highly endorsed by this Committee.

8—*Vital Statistics.* Heretofore, there has been confusion in reporting births and stillbirths. One physician reports at five months and another at four months. The size and the age (No. of months) have been confusing. Death before expulsion adds to the confusion. Now it apparently is a "legislative must" that all pregnancy be reported regardless of whether it is an abortion of the ovum, miscarriage of the foetus or the delivery of a baby. Whereas, it now stands that those above 20 weeks are reportable. The last date of menstruation is confusing. It has been proposed that the doctor report in inches (measured from the heel to the top of the head). The length of the baby, whether it died previously in utero or not. This then would relieve the profession of all responsibility as to age by months of pregnancy and a guess at duration by size. Inch rulers are available. The Committee endorsed this, provided there are no other lesser annoying methods available. Several other states have this system in use. Their systems need to be studied. The Bureau of Vital Statistics is most cooperative and will accent the way the Medical Association of Georgia wants it, provided it doesn't criss-cross something else up for them. They are querying the other states at the present time. Possibly it would be better that a small special committee

(from the Maternal Committee and the Vital Statistics Committee) of the Medical Association of Georgia study the situation and lend aid and advice to the Bureau.

9—*Publicity.* The Committee urges that more publicity be given Maternal Care in 1953 by a paper before the scientific session, an exhibit and the showing of the film "All My Babies."

10—*Refresher Course.* The Tri-State Seminar is recommended as an excellent refresher course for those interested in obstetrics.

Besides the communications on the educative program and all other contacts, the Committee met in person in Atlanta on March 11, 1953.

Thanks are extended for their great cooperation to this Committee, by the Division of Maternal and Child Health of the Georgia Department of Public Health, especially the enthusiasm of Dr. H. W. Bellhouse and to all others that aided in the compiling of the charts and graphs. The Bureau of Vital Statistics (Mr. Lacy and Miss Patillo) can claim their share of thanks also.

The Report was referred to Reference Committee No. 1.

REPORT OF COMMITTEE ON RURAL HEALTH

Frank Vinson, Chairman

The Committee on Rural Health of the Medical Association of Georgia held a dinner meeting September 25, 1952, with Dr. F. S. Crockett, of Lafayette, Ind., chairman of the council on Rural Health, American Medical Association, and Mr. Sid Wrightsman, Jr., executive secretary, MAG, present. Committee members present were Drs. Charles T. Brown, Clarence B. Palmer, Wilbur D. Hall, Rupert H. Bramblett, T. F. Sellers (ex-officio), and Frank Vinson.

Each committee member was instructed to assess the rural health situation in his own District, and select one county in which to try to initiate action towards the formation of a county health council. He is not expected to operate any resulting program, but to assist the county or community in solving its rural health problem.

The Chairman attended a meeting of State Committees on Rural Health Feb. 26, 1953, and the Eighth National Conference on Rural Health Feb. 27-28, 1953, both in Roanoke, Virginia. Subjects of paramount importance to rural health discussed included:

1. Group Health and Hospital Insurance, especially Blue Cross and Blue Shield.

2. Dental Health, with representatives of AMA and ADA stating that both Organizations have officially approved the fluoridation of water supply, under qualified supervision.

3. Nutrition, especially of children.

4. The constant theme of the meeting was the fact that the Council workers by cooperating with Health and Farm organizations aid communities to help themselves, rather than looking to Federal and State Agencies for help. Community Health Councils were highly recommended as one of the best agencies to work through.

Plans are being made for Committee members to meet with groups of internes, and possibly medical students, in order to present to them the advantages and rewards of rural practice.

The Report was referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON INDUSTRIAL HEALTH

A. M. Collinsworth, Chairman

As retiring Chairman of the Committee on Industrial Health of the Medical Association of Georgia, I wish to express my most sincere appreciation for your friendship, understanding and ever present interest in the problems this Committee has faced since June 1, 1952.

As you know an urgent call meeting was held on July 23, 1952 at the insistence of Dr. Lester Petrie, Director of Occupational Health of the State of Georgia, who was Vice-Chairman of this Committee. Dr. Petrie wrote me the week after appointments were officially

announced and gave his long range program for the establishment of small plant cooperative medical centers in industry with a "set-up" for complete on-the-job incurred injuries and personal illness requiring medical or surgical attention, in addition to preemployment and yearly examinations for the plant employees within these cooperative groups. This small plant program was voted down by this Committee, the vote being two for and nine against.

Since that time Dr. Petrie has demanded that he be given assurance of sponsorship by this Committee of other anticipated projects which are the Vocational Rehabilitation Center in Atlanta and the Planned Medical Service Center that is to occupy specified space in the new State Office buildings. These buildings are supposed to be available within the next two years. This proposed project of Dr. Petrie's will have a group of medical men from the Department of Public Health and other physicians specified to render complete medical and surgical services to some 3,000 State employees in the Atlanta area. This is to cover occupational as well as non-occupational injuries and illness. He insists on having Committee backing of an assured type for the next several years as he has long range programs that will need the support of the Medical Association of Georgia.

This Committee is of the opinion that a program of this type would be paid for by the taxpayers of the State of Georgia and would thus be unfair and would also be the organization and perpetuation of a form of Socialized Medicine within the State that would obviously be in competition with private physicians and surgeons. He also states that he will not be able to do these things without approval of State and local County Medical Societies.

The pressure exerted by Dr. Petrie upon this Committee and myself reached its climax in Chicago, January 20th at the A. M. A. meeting when, after long and arduous insistence that he must have some type of sustained Committee support, I was forced to tell him that I was not in a position to assure him of such.

The enclosed copy of letter to Dr. Allen H. Bunce, Chairman of the Committee on Constitution and By-Laws, clearly indicates that the Director of the Industrial Hygiene Division of the State Department of Public Health was considered as ex-officio member of this Committee. However, the newly appointed Director of the Industrial Hygiene Division is an engineer and not a physician. In his letter to Dr. Bunce he continues, "I am sure that it is the intent of the M. A. G. that the director of the Division of Occupational Health of the State Department shall be a member ex-officio of this Committee."

The planned work of the Committee on Industrial Health of the M. A. G. has been hamstrung by the early and consistent demands by Dr. Petrie that we sponsor his projects. We have been forced to expend our entire energies as a committee in efforts to neutralize these things we felt were not for the best interests of the membership of this organization. I do not believe an attitude of cooperation nor a constructive program can be carried out so long as he or any other representative of the State Department of Health is a duly appointed or constitutionally ex-officio member of this Committee. Thus, I am recommending that a revision of the Constitution and By-Laws be approved as herein specified.

I wish to call attention to the following Atlanta physicians who gave magnificent support to this Committee in opposition to Dr. Petrie at the July 23rd meeting: Dr. Charles S. Jones, Medical Director of the Ford Motor Company within this area and Dr. Duncan Shepard, Medical Director of the Atlanta Paper Company. These men have excellent initiative and very fine ideas as to what industry can do to meet the inroads of government sponsored medical programs. I suggest that you consider each of them as good material for your new committee for the year 1953-1954.

I am very appreciative to the M. A. G. for the opportunity of being this State's representative at the Thirteenth Annual Congress on Industrial Health that was held on January 20-22, 1953 at the Drake Hotel in Chicago. In

the year of 1952, the first year that each State Medical Society was requested to send the Chairman of their Industrial Committees, seventeen were present. This year the Chairmen from 30 States were present. Emphasis was placed on sponsoring programs that would better industrial working conditions throughout this country; ever-present leadership in prevention of occupational injury and disease; the making of safety programs a daily feature in every Plant; the encouragement of personal health in workers and problems as to how absenteeism can be reduced. It was indeed most interesting to hear the plans and problems as presented by labor union leaders, Management and Industrial physicians and surgeons.

As Chairman of the Committee on Industrial Health of the Medical Association of Georgia I make the following recommendations:

1. A concerted effort should be made to make standard the methods as to permanent disability evaluations in industrial injuries.

2. Teaching programs within the medical schools of this State should be a part of the studies within the third or fourth years that will give a reasonable approach to the problems of Industrial Medicine and Surgery so that each student will have a reasonable knowledge as to how this part of medical care operates.

3. Legislation changing the now existent inadequate law regarding compensation for hernia. It is an accepted fact that injury by accident arising out of and in the course of the employee's employment account for less than 1% of hernias. This problem needs classification as to occupations and up-to-date clarification of accident requirements. Hernia, with few exceptions, should be classified as caused by heavy, strenuous work and similar hazardous occupations, and is thus an occupational disease.

4. Legislation definitely needs to change the now existent \$750.00 limit for medical treatment of compensable cases. This State should have a law allowing unlimited medical above this amount, if the condition of patient requires such. This should also be granted by approval of the Industrial Board.

5. Encourage educational programs over this State that will give the General Practitioners the benefit of those basic features of the Workmen's Compensation Laws and encourage them to show more interest in this type of medicine and surgery.

I further recommend that in Chapter 9, Section 12 of the Constitution and By-Laws of the Medical Association of Georgia regarding the Committee on Industrial Health shall be revised and adopted to read as follows:

"The Committee on Industrial Health shall be composed of eight or more members so that there may be one from each of the major industrial areas in the State.

The Committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine.

It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employee and to solve other industrial health problems.

Should consultation with the Department of Public Health be necessary requests for same shall be forwarded to the State Director of this department.

It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association."

The Report was referred to Reference Committee No. 4.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Stephen T. Brown, Chairman

The Committee on Public Relations of the Medical Association of Georgia this year, for the first time since its inception, found itself on "new ground" in its activity, relegated, as it were, to advisory capacity at the 1952 Annual Session.

Where formerly the Committee was authorized to act on its own, in behalf of the Association and under the direction of a specific public relations director,

it now has been faced with the difficulty of merely suggesting to the Council policies to be carried out. When and if the Council's approval has been granted, procedures necessary to carry out such policies perforce have been left to the discretion and convenience of the Executive Secretary, who faced with myriad aspects of headquarters office administration, understandably cannot devote necessary time vitally requisite to the conducting of a first-rate public relations program.

It is the Committee's opinion that its most advantageous stride this year has been in the direction of noticeably improving physician-relations within the Association as a result of the Executive Secretary's cooperation with all Committees, the publicizing of their activities where warranted, with the establishment of a working liaison with the Woman's Auxiliary and its work in behalf of organized medicine in Georgia.

The one major medium of communication, which has served to keep Georgia physicians and Auxiliary members informed on AMA public relations policy and necessary state and national legislative trends, has been issuance of the monthly newsletter, *The MAGazine*, which, under Committee direction, is distributed throughout the nation and has received frequent commendation from abroad.

The Executive Secretary, in behalf of the Committee, attended the AMA Public Relations Institute in Chicago during September 1952 and the AMA Medical Public Relations Conference in Denver in December 1952. Recommendations made thereafter have been publicized to members through the newsletter and, particularly, at all District Society meetings which the Executive Secretary has made it his duty to attend during the past year in behalf of the Committee.

No statewide or regional medical press-radio conferences were held this year, mainly because funds for such purpose were never authorized. Nevertheless, informal press conferences sponsored by the Georgia Heart Association, at its annual meeting in Savannah in September 1952, and by the Editorial Board of the *Journal of the Medical Association of Georgia* in Atlanta in November 1952, received outstanding newspaper coverage throughout the state and indubitably served any need in that direction. The Committee sincerely believes, however, that increased effort along this line be undertaken by every county medical society in every community having a daily or weekly newspaper and/or a radio station. At least one county society meeting each year should be devoted to press-radio get-togethers with physicians and press-radio representatives.

During the past year, your Public Relations Committee has confined its activities to analyses of existing conditions—as they pertain to the relationship of the physicians and the public. In keeping with the trend in American Medical Association headquarters, we have endeavored to stimulate local societies to develop individual programs. A bulletin was prepared and distributed to all the component societies, outlining public relations projects that could be originated within the county society in hopes that each group would discard those which were impractical from its standpoint and capitalize upon—and put to use—those which were workable. Well prepared radio programs were from time to time distributed to various radio stations throughout the state. Under the direction of the local doctors who comprise the extended public relations committees, the coverage of the state with these interesting and informative series was excellent.

Considerable time at each of the meetings of the Committee was spent in discussing ways and means of presenting to the public a yardstick by which the consumer may measure the benefits of any voluntary prepaid insurance plan. It has repeatedly been brought to the Committee's attention that one of the great causes of discontent with existing voluntary plans is that the consumer fails to get the type of protection for which he thinks he is paying. The bulk of this dissatisfaction is evidenced by people who have purchased insurance from substandard companies on a dollar and cents comparison and have not examined their policies

closely. The Public Relations Committee feels that the doctors of the state must inform their patients in a helpful and intelligent manner. The work of the Committee should continue along these lines, with assistance from the Committee on Insurance.

From time to time editorials of great merit and worthy of wider distribution appear in our own *Journal*. With the permission of the editor, news releases containing such editorial comment have been prepared and sent to the press and radio throughout the state. This action is always well received.

Although progress has been made in all directions, much remains to be done.

The Public Relations Committee strongly recommends the preparation of a newspaper and radio advertising campaign by County Medical Societies. Copy in such a campaign should deal with the subjects of (1) The cost of medical care; (2) the doctors' participation in cancer, heart, polio, TB, and civic affairs; (3) the merits of Voluntary Prepaid Medical Care Plans. Such copy to be scheduled for use throughout the year and to be organized in such a way as to comprise a sound and effective institutional campaign.

Any and all public relations techniques utilized by the county societies are heartily endorsed by the Committee.

As Chairman, I should like to express gratitude to my willing and cooperative committee members, without whose efforts any success accomplished by the Committee would have been impossible. Furthermore, may I express much gratitude to Association Officers, Council members and to the staff of the Headquarters Office, all of whom have been quick to lend assistance to me in furthering activities of the Committee on Public Relations.

Finally, to reiterate recommendations herein:

1. The Public Relations Committee sincerely believes that the employment of full-time public relations director, under direct supervision of the Association headquarters office and the executive secretary, would seem absolutely necessary, in order that more field work could be accomplished. This would permit his continual attendance at county and district society meetings, along with the executive secretary when the latter's time permits, to sell local physicians on the importance of a workable public relations program. Such public relations man could periodically call on local newspaper editors and radio representatives (in the name of the local county society) and encourage meets among the groups.

2. In behalf of our members, the Committee recommends closer cooperation in the future between the headquarters office and our Committee on Legislation. Only through such cooperation may the members be informed about specific bills affecting the medical profession and what they, as members, should do about them. It is our recommendation that, during state legislative meetings, a periodic bulletin be sent from the headquarters office to each physician and Auxiliary member, summarizing controversial bills and advising about necessary action to be taken. Such bulletin, under the direction of the Legislative Committee Chairman, might well be patterned after the AMA Washington Office Report.

3. The Public Relations Committee believes that now is the time to promote aspects of public relations in the field, serving to establish the firm foundation for survival of unfettered medical practice against future onslaughts which are bound to occur.

The Report was referred to Reference Committee No. 3.

REPORT OF THE COMMITTEE ON CANCER

J. Elliott Scarborough, Chairman

The Committee on Cancer of the Medical Association of Georgia held its first meeting on September 18, 1952. All the members of the Executive Committee were present and in addition, Dr. W. J. Murphy of the Georgia State Cancer Control Service and Mr. Lon Sullivan of the Georgia Division of the American Cancer Society attended by invitation. The agenda consisted of a discussion of those cancer clinics temporarily approved by

the State for service to the State-Aid patients and not located in state approved hospitals. It was decided to do everything possible to encourage these clinics but if they have not made every effort to get their hospitals approved it would be recommended that they be dropped from the list of State-Aid approved clinics.

The survey of "Operating and Potential Clinics for Cancer Diagnosis in the State of Georgia" made by the National Cancer Institute was discussed. It was decided that although it served to condense information there was nothing new in it and certainly no rule of thumb could be adopted as a basis for the establishment of State-Aid clinics. Dr. Murphy was authorized to continue operation on the basis of 100,000 population per clinic.

Other minor points concerning remuneration for the treatment of cancer patients in hospitals was discussed. It was recommended that patients be treated as out-patients as much as possible and no basic change made in the program which operates on a percentage of the per diem cost.

On numerous occasions problems incidental to the Department of Cancer Control and the American Cancer Society have been taken up with the Chairman. On one occasion where the State Cancer funds were requested for prosthetic materials for cancer patients the Executive Committee was polled for their opinion of the desirability of this procedure. With one exception it was disapproved.

On February 4, 1953 Dr. Oliver B. Zeinert visited the State from the American College of Surgeons for the purpose of inspecting approved established cancer clinics. Dr. Zeinert worked in close cooperation with the Committee on Cancer and it is believed that this will result in improving the status of existing clinics and probably make possible the development of other clinics in new areas.

The Committee continues to enjoy a close working relationship with the Georgia Division of the American Cancer Society and the Society is being encouraged to develop its program of professional education which should result in better diagnosis and treatment for the cancer patient.

The Report was referred to Reference Committee No. 4.

REPORT OF THE COMMITTEE ON INSURANCE

W. S. Dorough, Chairman

The Committee on Insurance has functioned normally throughout the year in its administration capacity with reference to the "Georgia Plan." There have been many questions to be answered and many decisions to be made in the unlisted procedure category. These have been handled with a minimum of delay. As a whole, the administration of the plan has been very smooth. Co-operation of the doctors and the insuring agencies has made this possible.

The progress of the Plan has been most gratifying. At the present time there are 110,000 people insured under the "Georgia Plan" and the number is steadily growing each month. While this may seem slow progress to some, it has been sound, stable progress without difficulties as experienced by other plans.

Members of the Committee have met with civic groups and other organizations interested and participated in discussion of health and health insurance. Many individual queries have been answered also. The Secretary of the Georgia C. I. O. appeared before the Magnuson Commission and made a report on Medical Care in Georgia. There were some misstatements of fact in this report and these were called to his attention by letter. A copy of this letter was forwarded to the Magnuson Commission. The members of the Insurance Committee feel that much has been accomplished in the education of the public in regard to responsibility of its health. Since 1947 the individual surgical and hospital insurance has increased 45% in the State of Georgia and group surgical and hospital insurance has increased 320%. These figures represent the period between 1947 and 1951 inclusive. Hospital Insurance, alone, which has been sold for

many years increased 78% in this same period. There are no figures for 1952 but we feel sure that there has been a further increase as it is reflected in the increased number of blanks to be filled out by the doctors. This is most gratifying, for the economic status of the patient and doctor will certainly be improved as more insurance is sold.

The Committee recommended that the Council of the Medical Association place its stamp of approval upon the Blue Shield organization of Columbus as it had met the requirements and had been approved by the Committee of the AMA. The Council approved it as a recognized Blue Shield organization. They have over 30,000 insured under their plan.

Members of the committee have met with representatives of the Insuring agencies in an effort to try to work out a uniformity of blanks both for hospital and health insurance. The hospital blank has been perfected and is now in use. It is difficult to get a uniform health blank but a committee of the Association is making a study in an effort to find a simplified form. The paper work of the doctor is becoming increasingly heavy and any relief will be welcomed.

Upon the recommendation of the Committee on Insurance, the Council authorized the appointment of five laymen to serve with the Committee as a Board. The labor organizations on lay groups which should be represented on the Board and a letter requesting two representatives to be appointed was sent to the labor organizations. As this was an election year both nationally and locally in the labor organization they asked that this be deferred until after the first of the year. This can possibly be accomplished now, but as the appointment of a new committee is only a month or two away, your present Committee feels that the new committee should have its choice in selection of the five lay members. This should be done as early as possible after the appointment of the new Committee on Insurance.

Finally, may I call members' attention to the lead editorial in the March ('52) issue of *Medical Economics*. A careful perusal of this article, explaining trouble encountered by the California Physicians Service (Blue Shield) in stabilizing its fee schedule, will indicate your Committee's farsightedness in establishing the type of coverage offered by The Georgia Plan.

The Committee wishes to take this opportunity to express its sincere appreciation to our Executive Secretary, Mr. Wrightsman who has handled a major portion of the administrative work relating to the "Plan" in a most able and capable manner. We wish a most successful year for the Plan and the new committee which will administer it through the coming year. A review of revision of the fee schedule making it more complete should be made during the year with as much data has been collected in the two years of operation. A revised schedule would clarify many questions for the increasing agencies and the doctors.

We are most grateful to the doctors and insuring agencies for the excellent cooperation tendered the present committee and request the same for the incoming committee.

This report is respectfully submitted to the Council for its approval or disapproval.

The Report was referred to Reference Committee No. 1.

REPORT OF THE ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Ralph H. Chaney, Chairman

The Advisory Committee of the Woman's Auxiliary met in Macon, Georgia together with the Executive Committee of the Auxiliary. The plans of the Auxiliary were reviewed and were approved for the ensuing year.

The Auxiliary should be complemented on carrying out a comprehensive and expanded program.

The Report was referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON AWARDS

Mark S. Dougherty, Chairman

The Medical Association of Georgia has no formal awards which are given except the Ware County Cup which is given by the Ware County Medical Society for outstanding achievement in the field of Public Health and for the awards which are given for Scientific Exhibits and the Certificate of Appreciation given for service in the Association. The Committee would like to request the secretaries of the county medical societies to send in the names of any doctors doing outstanding work in the field of Public Health so that the Committee may consider awarding the Ware County Cup.

The Committee would like to recommend that the Certificate of Appreciation be given to Doctor Marion C. Pruitt who has served many years on the Council of the Medical Association of Georgia. Doctor Pruitt has rendered outstanding and loyal service to the Association.

We would like to recommend also that the Certificate of Appreciation be awarded Doctor Spencer Kirkland who has been Chairman of the Committee on Public Policy and Legislation for a long period of years and has rendered faithful outstanding service to the Medical Association of Georgia.

The Committee is taking into consideration the question of awards and will make suitable recommendations at the forthcoming meeting in Savannah.

Chairman Dougherty of the Committee on Awards submitted the following supplementary report:

1—Committee on Awards has made the following awards: One Certificate of Appreciation was awarded to Marion Pruitt for his outstanding work and service to the Medical Association of Georgia as a member of Council for a period of many years.

2—Spencer Kirkland was awarded a Certificate of Appreciation for long and valuable service as Chairman of the Committee on Legislation.

3—Lombard Kelly was awarded a Certificate of Appreciation for his outstanding service in the field of Medical Education.

4—Charles Daniel Bowdoin was awarded the Ware County Cup for his outstanding achievement in the field of Public Health.

The Committee on Awards has studied the question of awards to be made by the Medical Association of Georgia and wishes to make the following recommendations:

1—That an award of a plaque be offered annually by the Medical Association of Georgia for original research work.

2—That an award be offered by the Medical Association of Georgia to one of its members for outstanding contribution in the field of community service.

3—That a gold medallion be given for first award, a silver medallion be given for the second award, and a certificate be given for the third award for the three winning scientific exhibits, provided sufficient numbers are presented to warrant such awards.

The initial and supplementary Reports were referred to Reference Committee No. 2.

REPORT OF COMMITTEE ON CONSTITUTION AND BY-LAWS

Allen H. Bunce, Chairman

CONSTITUTION

Article VI. Sec. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Councilor District in the State of Georgia.

Article VIII. In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts which may be co-extensive with the Congressional Districts in the State of Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Article IX. Sec. 1. Officers. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor and a Vice-Councilor from each of the Councilor District Societies, as

provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

(NOTE: The above amendments to the Constitution were proposed last year and are to be voted on at this session.)

BY-LAWS

Chapter III. Sec. 2. Change the wording, "whose dues have been paid by March 1st of each year" to "whose dues have been paid by December 31st of the preceding year."

Sec. 4. The House of Delegates shall be presided over by a Speaker, or a Speaker pro tem, whose election shall be the first order of business at the final meeting of the House at each Annual Session. He shall serve until his successor is elected and installed.

Sec. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, a delegate appointed by the President. The Executive Secretary may serve in this capacity.

Sec. 6. The following shall be the general order of business at the meetings of the House of Delegates: 1. Call to order by the President; 2. Roll Call; 3. Reading and adoption of Minutes; 4. Reports of officers; 5. Reports of committees; 6. Unfinished business; 7. New business.

Sec. 7. For the purpose of expediting proceedings the Speaker shall appoint from the members of the House of Delegates the Reference Committees, etc.

Chapter VI. Sec. 4. The Secretary-Treasurer. (a) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and, etc.

Chapter VIII. Sec. 1. (Add the following paragraph at the end of this section): An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

Chapter IX. Sec. 12. (Change the second sentence to read as follows): The Director of the Division of Occupational Health of the State Department of Public Health shall be a member ex-officio.

RESOLUTION: HONORARY ADVISORY BOARD

WHEREAS, The Medical Association of Georgia at its Annual Session in 1925 created a permanent Honorary Advisory Board to be composed of all Past Presidents of the Association; and

WHEREAS, The Honorary Advisory Board was then given the continuing duties of (1) collecting, writing, editing and supervising the publication of material concerning the history of medicine in Georgia to the end that a book to be known as the History of Medicine in Georgia (or other suitable title) could be published, and (2) collecting advance subscriptions to be held in trust until the books should be delivered to the subscribers or their heirs, or refunded; and

WHEREAS, this board caused to be collected and published a complete and detailed history of the Association from 1920 to 1935 and such a history of the Woman's Auxiliary from its beginning to 1935 and, in addition, numerous members of the Board have collected and published and caused to be collected and published many articles on the history of medicine in Georgia since its founding as a colony; and

WHEREAS, this Board collected advance subscriptions up to 1935 to the amount of \$1200.00 which it placed in a savings account which up to 1943 had increased to \$1330.12;

BE IT RESOLVED, that the Association extend the duties of this Board to include that of long range policy and planning for the Association and report its recommendations to the Council at least once annually.

This Report was referred to Reference Committee No. 3.

REPORT OF THE COMMITTEE ON THE AMERICAN MEDICAL EDUCATIONAL FOUNDATION

Tully T. Blalock, Chairman

During the year 1952, your committee was organized with a sub-chairman representing each district to assume the responsibilities of canvassing the counties in his respective districts. These sub-chairmen were then contacted and requested to encourage their local county secretaries to make personal contacts with their individual members in order to secure a donation from each

member.

The Medical Association of Georgia has been cooperative with this committee in presenting material in the *Journal* advertising the American Medical Educational Foundation and requesting donations. As a result of this effort, during the year 1952 and up to February 28, 1953, the total donations from individuals amounted to \$2,743.50 from 72 contributors in 30 counties. This was added to the \$10,000 donated from the Treasury of the Medical Association of Georgia. Your Chairman attended the annual meeting of the American Medical Educational Foundation in Chicago on January 25, 1953, where he met with representatives from every other state to discuss plans for the future campaign.

It is planned to have an exhibit at the State Meeting in Savannah on May 10th to 13th, and this committee has secured special exhibits from the National Headquarters.

I wish to especially commend the assistance of Mr. Sid Wrightsman who has been valuable in maintaining records and in performing clerical work.

It is urged that a new Chairman be appointed for this committee, preferably one that could donate the necessary time and effort to this most important cause.

The Report was referred to Reference Committee No. 4.

REPORT OF COMMITTEE ON BLOOD BANKS

James C. Thoroughman, Chairman

Your Committee on Blood and Blood Derivatives is a new committee appointed at the suggestion of the American Medical Association. Dr. Herbert Ramsey, Co-Chairman of the A. M. A. Committee on Blood Banks, has been most gracious in providing counsel in matters of policy and organization. The Committee has three broad objectives: (1) To gather statistical information regarding the procurement and use of blood and blood derivatives in the state; (2) to make accessible new information pertaining to blood and blood derivatives; (3) To afford a medium through which groups having related interests might correlate their interests and discuss their problems.

The initial work of the Committee was organization. In accordance with the recommendation of the Committee on Blood and Blood Derivatives of the American Medical Association and with the approval of the Council of the Medical Association of Georgia, representatives of the following organizations were requested to participate in the work of the Committee:

1. Southeastern Area American National Red Cross
2. Georgia Association of Pathologists
3. Georgia Hospital Association
4. State Civil Defense
5. State Health Department

A meeting was held in Marietta November 17th, and the Committee voted to gather statistics regarding the blood banks in Georgia. Inasmuch as many problems of this Committee were common to Civil Defense, the committee requested the Director of Civil Defense to designate a Civil Advisory Committee on Blood and Blood Derivatives so that the two committees could correlate their work. Dr. T. F. Sellers has appointed representatives of the following organizations to act as Advisory Committee on Blood and Blood Derivatives to Civil Defense:

1. Southeastern Area American National Red Cross
2. Georgia Association of Pathologists
3. Georgia Hospital Association
4. Health Section of State Civil Defense
5. State Health Department
6. Medical Association of Georgia

With the assistance of the Executive Secretary of the Medical Association of Georgia, a list of the blood banks in the State has been compiled and is attached as Appendix A. As far as our Committee can ascertain there are 26 blood banks in the state.

List of Blood Banks

Dr. R. H. DeJarnette
Vidalia, Georgia

Billy Smith, Administrator
Winder-Barrow Hospital
Winder, Georgia
Laurens County Hospital
Dublin, Ga.
University Hospital
Augusta, Ga.
Sumter County Hospital
Americus, Ga.
Hamilton Memorial Hospital
Dalton, Ga.
Dr. Milton Freedman
848 Peachtree St., N.E.
Atlanta, Ga.
Crawford W. Long Hospital
Atlanta
Dr. L. D. Arbuckle
702 Stiles Ave.
Savannah
Kenneston Hospital
Marietta, Georgia
Athens General Hospital
Athens, Ga.
Hall County Hospital
Gainesville, Ga.
Phoenix City Hospital
Phoenix City, Alabama
Columbus City Hospital
Columbus, Ga.
St. Francis Hospital
Columbus, Ga.
Appling General Hospital
Baxley, Ga.
Phoebe Putney Hospital
Albany, Ga.
Macon Hospital
Macon, Ga.
Little Griffin Hospital
Valdosta, Ga.
City County Hospital
LaGrange, Ga.
Floyd County Hospital
Rome, Ga.
Mitchell County Hospital
Camilla, Ga.
Dr. W. L. Pomeroy
901 Jane St.
Waycross
Jelks Hospital
Reidsville, Ga.
Vereen Memorial Hospital
Moultrie, Ga.
Griffin Spalding County Hospital
Griffin, Ga.

Appendix B

MEDICAL ASSOCIATION OF GEORGIA Committee on Blood Banks

J. C. Thoroughman, M.D., Chairman
Veterans Hospital
Augusta, Ga.

BLOOD BANK SECTION OF THE ANNUAL CENSUS OF HOSPITALS—1952 BLOOD USED AND PROCURED

1. Do you bleed and store whole blood for later use for for unspecified patients: If stored only for a named patient, you should check "No."
Yes _____ No _____
1a. If "Yes," how many of these units were procured directly from donors bled anywhere in your hospital in 1952? _____
2. How many units (500cc.) of whole blood from all sources were administered in your hospital in 1952? _____
2a. Of this amount, how many units were administered in immediate transfusions without storage of blood? _____
3. In 1952, how many units of whole blood did you obtain from:
1) Other hospital blood banks _____
2) Non-hospital blood banks _____

*NAME	1.		1a.	2.	2a.	3-1	3-2	3-3	4.
Columbus #1	Yes	—	3408	3148	0	22	0	28	5-15
Albany	Yes	—	1000	1000	250	25	0	0	50
Macon	Yes	—	7228	6864	10	20	0	100	150
Moultrie	—	No	—	644	1/3	—	—	—	4-8
Griffin	Yes	—	275	1134	12	6	—	859	25
Baxley	Yes	—	all	625	—	—	—	—	18
Columbus #2	Yes	—	975	663	20	15	—	—	15-20
Camilla	—	No	—	150	75	—	—	3	3
Rome	—	No	—	1608	—	—	—	15	40
Waycross	Yes	—	1271	977	—	—	4	10	40
Valdosta	Yes	—	all	208	20	—	—	—	6
LaGrange	Yes	—	617	1244	—	—	—	627	20
Reidsville	Yes	—	15	52	15	—	—	—	2
Dublin	Yes	—	400	300	—	20	20	—	25
Americus	—	No	—	315	30	—	—	285	6
Phoenix City	Yes	—	720	840	—	120	—	—	14
Atlanta Reg. ARC	Yes	—	61521	36343	—	—	—	—	75
Athens	Yes	—	662	1399	—	—	—	737	15
Savannah	Yes	—	—	—	—	—	—	—	150-200
Augusta	Yes	—	6448	8566	—	—	—	1166	10
Winder	—	No	—	—	—	—	—	—	—
Marietta	—	No	—	1533	—	—	—	1533	12-15
Crawford W. Long	Yes	—	3226	5599	12	—	—	2373	103
Dalton	Yes	—	683	683	15	—	—	—	25
Gainesville	Yes	—	274	703	—	32	—	429	2-27

1. Blood Stored for Later use
- Blood Only for named Patient
- 1a. Number Units procured
2. Number Units given during year 1952
- 2a. Units given without storage

- 3-1 Units from other hospital blood banks
- 3-2 Non-hospital blood banks
- 3-3 Red Cross Regional Centers
4. Average Stock Whole Blood on Hand

- 3) Red Cross Regional blood centers
4. Specify the average stock of whole blood on hand

A survey on these blood banks was conducted and statistics from 25 blood banks reporting is attached as Appendix B. It is noted that 38,254 units of blood were administered from these banks during the year 1952. This does not include blood used in any of the military or veterans hospitals in the state. Undoubtedly blood is being used in considerable amounts which is not obtained from any of the blood banks listed here. Eight groups reported that they had obtained blood from other blood banks and thirteen reported that they have received blood from Red Cross Regional Centers. The Atlanta Regional Blood Center, American National Red Cross Blood Program, furnished 36,826 units of blood for civilian hospitals in Georgia, and 24,695 pints of blood for defense the calendar year of 1952.

The Report was referred to Reference Committee No. 1.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE SYSTEM

Carter Smith, Chairman

During the year of 1952, the available men in Category #1 have not been called to duty.

Category #2 has about reached the point of exhaustion, it being necessary to call men back to duty who have had from sixteen months to as much as twenty months previous service in the Armed Forces. It is unfortunate that these men have been forced to be recalled to active duty when men in Category #1, who have never served are still in practice.

Category #3, is now being processed but there are very few men in this category under the age of 40 and the Armed Forces are not enthusiastic about calling to duty men in Category #3 above the age 40 because of the difficulties in their dislocation and because of a high degree of rejections for physical disability which exists in this group as compared to the younger physicians.

Attempts are being made to influence the national policy in its thinking in regard to the passing of a new law which will replace Public Law 779 as it expires on July 1, 1953. It is being recommended by the various county medical societies throughout the country that classification be changed so that instead of the present four categories, there will be only two classifications; being called "A" and "B". Classification "A" would comprise all physicians who have never had service in the Armed Force, and they would be called according to their age levels; Classification or Category "B" would

be composed of all physicians who have had previous service in the Armed Force and would be called according to their length of previous service in the Armed Force. This would be a much fairer way of operating a Selective Service system for physicians.

In order to carry out this program successfully and fairly, it would be necessary that the local draft boards be stripped of the power to declare a physician essential to a community without first having a consultation with the Advisory Committee to Selective Service, regarding the true essentiality of the physician. In this way, it is hoped that the decision of essentiality can be based on its real merit rather than on local political influences.

Not until this method becomes effective will it be possible to have the call to the Armed Forces of physicians carried out in a just and fair manner.

It is also recommended to the National Advisory Committee in Washington that the chairmanships of the state and local committees be rotated each year or two and this has been done in the State of Georgia; Dr. A. O. Lynch became chairman on 1 January 1953, of the Medical Advisory Committee to Selective Service in the State of Georgia.

It is also felt advisable by the State Advisory Committee to reorganize the local Committees on a district rather than a county basis with the exception of the five large cities of the state and, even in some instances, these could become districts rather than County Committees. This reorganization has been effected and is now operating in a manner that will be more satisfactory than the local county committees.

Any suggestions for improvement of our operation of the State Advisory Committee to Selective Service will be appreciated by the Committee.

Secretary Poer, as a member of the Committee submitted the following resolution in behalf of the Committee, as an addendum to the printed report:

"BE IT RESOLVED, that the members of the Medical Association of Georgia express its appreciation to all Draft Boards in the State that are cooperating with this Committee in the difficult task of selecting doctors to serve in the military forces, and

"That the same letter of appreciation be sent to the Director of the Selective Service System in the State, and

"That the Director also be requested to use every means at his disposal to see that all physicians in Priority I and II

be called into service before calling those in Priority III, and "That he specifically be requested to review personally the cases now pending in the State, where the Local Draft Board has not followed the advice of this Committee; and take all necessary steps to cause the induction of non-essential physicians, even if it requires the appointment of a new draft board."

The Report, with addendum, was referred to Reference Committee No. 2.

REPORT OF MEDICAL CIVILIAN PREPAREDNESS COMMITTEE

Edgar M. Dunston, Chairman

This year again the work of the Committee was intimately connected with that of the Medical Services Branch of the State Civil Defense Health Services Division, which has been in operation since February 19, 1951. Our Committee is the main advisory group for this Branch. Full minutes of the activities of this Branch are in the official files.

Representatives of this Committee attended the regular monthly school sessions and other meeting of this Branch throughout the year and participated prominently in the following key activities:

1. Distribution of some 30,000 of the *Georgia Civil Defense Health Services Plan (A Summary)* to all of the professional and technical personnel and to the key personnel in the non-professional groups mentioned in the Plan.
2. Publishing and distributing 6,000 copies of the official *Mannual for Organization of Improvised Civil Defense School-Hospitals* written by Committee-man Dr. Charles Eberhart.
3. Publishing and distributing 6,000 copies of the technical manual, *The Nurse in Civil Defense in Georgia*.
4. Publishing the article, *Civil Defense Health Services Plan, Supply and Operations*, by Dr. Edgar M. Dunston, in the September 1952 issue of the *Journal of the Medical Association of Georgia*.
5. Presentation by the Chairman of the Committee of of a paper, *The Georgia Civil Defense Plan for the Treatment of Mass Casualties*, before the 1952 Annual Meeting of the Southern Medical Association and publication of this article in the February 1953 issue of the *Journal of the Southern Medical Association*.
6. Completion of the first *Pilot Course in Training for Dentists in the Medical Aspects of Atomic Warfare*, sponsored jointly by the Northern District Dental Society, Georgia Civil Defense Medical Services Branch, and Grady Memorial Hospital in January-February 1953. This course will serve as a model for other district dental societies, and for the Veterinary, Osteopathic and Pharmacist groups.
7. Participation in Community Civil Defense Services Programs in Atlanta, Augusta and Macon.
8. The Committee has also been busily engaged in the completion of the other manuals mentioned in the basic plan and in urging all concerned to organize and train for their respective duties.
9. Two members of our Committee have been appointed on the Medical Advisory Committee of the Southeastern (Third) Regional Medical Office of the Federal Civil Defense Administration.

The soundness of our planning has received national recognition. Brigadier General William L. Wilson, Assistant Administrator, Health and Welfare, Federal Civil Defense Administration, recently visited our State. The Atlanta *Constitution* reports this visit thus:

Georgia doctors have mapped out a 'rational and good' plan for pooling their resources to meet a possible enemy attack anywhere in the state, Brig. Gen. William L. Wilson said here Tuesday.

The general is assistant administrator for health and welfare in the Federal Civil Defense Administration in Washington. He is visiting all FCDA regional offices to see provisions made to care for

wounded and homeless people in event of enemy bombing.

Georgia's preparations are far ahead of most other states. General Wilson said, 'You have a written plan that is clear and simple and an understanding of what you want to do next, he explained.

As far back as 1949, the general said, Georgia Medical groups became concerned about their part in Civil Defense and worked out plans for improvised hospitals and transportation of medical supplies in an emergency.

The most important thing of all is what happens to individuals and families in a bombed city. Civil Defense's problem will be to mend the injured person and put him mentally at ease so he can go back and rebuild his community, General Wilson said.

The Commanding General of the Third Army has issued its Certificate of Achievement for the formulation and implementation of the Georgia Civil Defense Health Services Plan. The Board of Trustees of the American Medical Association has honored our Committee by appointing its Chairman as a Consultant to the Council on National Emergency Medical Service.

Recommendations

Since it is now more than ever urgent that the Georgia Civil Defense Health Services Plan be implemented at all levels, it is recommended that the structure of the Medical Civilian Preparedness Committee of the Medical Association of Georgia be continued as in the past year. Specifically, there should be a committeeman from each district medical society with an executive committee of three members in Atlanta to work in close liaison with the Medical Services Branch of the Georgia Civil Defense Health Services Division. Further, it is again urged that these district representatives work in close cooperation with the District Women's Auxiliaries so as to reach all personnel concerned in all the districts throughout the State.

The Report was referred to Reference Committee No. 3.

REPORT OF COMMITTEE ON COMMITTEE REORGANIZATION

W. F. Reavis, Chairman

The report of the Committee on Committee Reorganization will be included with the Committee on Constitution and By-Laws and we will not have any formal report to make.

The Report was referred to Reference Committee No. 3.

REPORT OF THE COMMITTEE ON VETERANS AFFAIRS

Hartwell Joiner, Chairman

I am reporting on the G. A. M. committee on Veterans Administration.

1. In all sessions, we agreed that we would establish a liaison between the medical profession and the Veterans Administration office in Atlanta, Georgia.
2. Request that all physicians having complaints or recommendations to the Veterans Administration in regard to medical or surgical service to veterans be requested through this committee.
3. That this committee make its recommendations to the counselors after discussion with them.
4. We recommend that the chairman of this committee for the next year and the committeemen call a meeting twice a year with the Veterans Administration office in Atlanta, go over all complaints, recommendations and suggestions jointly, present these in writing, both the Administration and the M. A. G., and if any changes are made—that they be published in the G. A. M. and the M. A. G. *Journal*. We request that we keep all affairs between the two organizations as simplified as possible.

On behalf of Chairman Joiner of the Committee of Veterans Affairs, Secretary Poer presented the following Committee recommendations as an addendum to the printed Report:

1. That the delegates to the state convention instruct the delegates to the A.M.A. to take a resolution requesting that all veterans sent in to V.A. hospitals by private physicians, and all veterans dismissed from V.A. hospitals, to the outpatient care of private physicians be dismissed from those hospitals, with a copy of the history, physical, diagnosis and recommendation of the treatment, instead of indefinite or vague terms such as nervous conditions, etc., which means nothing.

2. Send two delegates to the A.M.A., and present resolutions requesting uniformity in fees to veterans over the entire country. This will save a lot of confusion. And the thing that reminds us to do this, is that Florida doctors got a fifty per cent raise in their fees.

3. That complaints, recommendations, and suggestions be made in writing, by the doctors to the Veterans Committee.

The Report, with addendum, was referred to Reference Committee No. 4.

REPORT OF THE COMMITTEE ON CHRONIC ILLNESS

L. Minor Blackford, Chairman

Chronic illness is not a synonym of old age. Such illnesses as congenital heart disease, harelip, cleft palate and other anomalies, club foot, cerebral palsy, difficulties in seeing, hearing and speaking, fibrocystic disease of the pancreas and adrenocortical insufficiency, may date from birth, or even earlier. In childhood, rheumatic fever and resultant heart disease, infantile paralysis and disabling injuries are the most important long-time ailments, but mental deficiency and mental retardation, as well as epilepsy, emotional disturbances and even psychoses are also important. While the facilities for the care of white children with mental diseases cannot fill us with pride, there is no institutional bed in Georgia for an epileptic or mentally deficient child if his skin be black.

The sequelae of the conditions enumerated loom large in early adult life, and tuberculosis and trauma, including industrial accidents, become even more important. Cancer and leukemia may occur at any age, but they are more common later in life, and then degenerative diseases begin to take their toll.

The major role in the care of the chronically ill in Georgia is rightly borne by the State. The largest institution for such care is, of course, the State Hospital at Milledgeville. During the administration of Governor Herman Talmadge this has been vastly improved, but it does not yet rank with the best. In the Battey Hospital the problem of tuberculosis is being better handled today than ever before in Georgia, but here too there is room for improvement. The Gracewood School for whites, though horribly overcrowded and woefully understaffed, under the direction of Dr. Norman B. Pursley is better run than ever before, and the recent Legislature appropriated funds to enlarge it.

In 1938 the State, with federal aid, began to do something about our handicapped children, but it was a long time before it granted that a child may be just as effectively crippled with heart disease as with other more visible afflictions. In July, 1951, the Crippled Children's Division of the Department of Public Welfare was transferred to the Department of Public Health, and since then the Division has vastly expanded its services. Today "permanent" treatment centers for crippled children are located in Atlanta, Augusta, Savannah, Thomasville, Columbus and Macon. In these centers adequate hospital facilities are available as well as doctors highly trained in the necessary specialties. "Itinerant" clinics have also been started in Albany and Cordele, and others are planned. A Negro therapist has been assigned to the Harris Memorial Hospital in Atlanta for the treatment of colored children, both as in-patients and out-patients. And our State Department of Education's Division of Vocational Rehabilitation is recognized as one of the best there is.

In addition to the tax-supported agencies struggling with these problems, may be listed the Infantile Paralysis Foundation, the Scottish Rite Hospital, the Elks' Aidmore, the Henrietta Egleston Memorial Hospital for Children, the Georgia Society for Crippled Children, the Cerebral Palsy Society of Georgia, the Better Health Council of Georgia, the Georgia Heart Association, the Tuberculosis Association, the Georgia Cancer Society and the Red Cross.

Of the private organizations, the Infantile Paralysis Foundation is so well known for its splendid work that comment here is unnecessary. The Scottish Rite Hospital for the correction of orthopedic troubles in white children is equally fine. The Elks receive both white and colored children at Aidmore; this is the only place in our State for children convalescent from rheumatic fever. The Egleston, which from its founding has accepted white children from all over the State, now has funds on hand for great expansion; when this is accomplished, it expects to receive also colored children.

The Georgia Society for Crippled Children is now working for the benefit of all handicapped children. The Vice President and the Secretary are doctors' wives, but of the thirty-five directors only two are physicians. Members of our Association ought to exert more leadership in such organizations: the day is gone when a doctor can be content to do nothing but give his best to those who seek his aid.

The Society for Crippled Children and the Cerebral Palsy Society, sparked by Mr. Mills B. Lane, Jr., last fall organized a central committee of more than a hundred to survey the needs of chronically ill children in Georgia and to find out what can be done to meet these needs. To head this survey they have employed Dr. Samuel M. Wishik, and the survey is receiving enthusiastic assistance from doctors and lay persons throughout the State. While the job will hardly be completed for another year, on December 15, 1952 the central committee met and drew up a list of the greatest needs at this time. A petition setting forth the urgency of these needs was submitted to the Governor, and a delegation waited on Lieutenant Marvin Griffin with a copy of the petition. It is probable that the appropriations for special training to teachers of the handicapped and for the improvement of Gracewood, resulted from this petition; it is hoped that the other requests will be taken up when the Legislature reconvenes in the fall.

The primary responsibility for chronic illness, however, lies with the general practitioner. He should detect such conditions as early as possible. He is prepared to handle many of them himself, but he should learn what facilities are available for the treatment of those he can not treat, and he should see that his patients have the advantages of these facilities.

The Georgia Better Health Council is another agency that is doing a wonderful job. Every year it holds meetings in various parts of the State that attract people from twenty-odd counties. At these meetings local health problems and what to do about them are discussed, for the most part by the citizens of that area. Last fall Dr. F. S. Crockett, Chairman of the A. M. A. Committee on Rural Health, attended one of the meetings and was so much impressed with the work of the Council that he suggested that the Medical Association of Georgia should assume full financial responsibility for it.

The Georgia Heart Association, in cooperation with the State Department of Health, has established heart clinics in Atlanta, Athens, Augusta, Albany, Savannah, Brunswick, La Grange, Macon, Columbus, Waycross and Thomasville. (It is not the fault of the Heart Association that there is no clinic north of Athens and Atlanta.) These clinics have diagnostic facilities adequate for most cases of heart diseases. In cases requiring hospitalization for cardiac catheterization or surgery, the Crippled Children's Division makes these possible. Recently the Division has authorized the chief of each local clinic, in cases of emergency to hospitalize children with heart disease before notifying the central office. When a child with heart disease does not live near one of the local heart clinics, he can be brought to the Division's clinic

in Atlanta to determine if he needs anything out of the ordinary.

Vocational Rehabilitation is also sharing in the care of cardiacs a little older, retraining persons who must learn a new way to make their living, and meeting the expenses of cardiac surgery in selected cases.

Your Committee hopes that eventually a Regional Vocational Rehabilitation Center for white people (an excellent one for Negroes in Tuskegee, Alabama is now training a number of Georgia citizens) will be set up in Atlanta.*

The proposed Center will be under the direction of the Division of Vocational Rehabilitation with its staff of medical and surgical consultants. The patients, while receiving the best possible treatment of their disabilities, will learn trades to render them economically independent. The Center will expect to receive patients from South Carolina, Florida, Alabama, Tennessee and more distant States. The expenses of many of the patients will be met by their own States; of others by churches, fraternal orders, insurance companies, United Mine Workers of America and similar organizations. A few will pay their own way. Once launched, this is not an expensive program for rehabilitation pays dividends: it can often turn a miserable object of public assistance into a happy tax-payer.

The needs of Georgia are great. This fact is tragically illustrated in the percentage of our boys rejected by the Army, one of the highest percentages in the country. We need more psychiatrists, more psychologists, more teachers specially trained to teach handicapped children, both white and colored. We need more social workers and psychiatric case-workers, more occupational therapists and physical therapists. Atlanta University has a good school for the training of colored social workers, but there is no place in Georgia where a white person can be trained as a social worker, an occupational therapist or a physical therapist. We should have such schools, and that for physical therapists will have to be affiliated with one of the medical colleges. Georgia-born and Georgia-trained technicians are more apt to stay here than those imported from a distance, but not all will stay while the demand for such highly skilled personnel remains so high in other parts of the country.

For those who cannot be rehabilitated, institutional care is often necessary. The State Department of Public Welfare lists twenty-four institutions, neither tax-supported nor run for profit, for the care of the chronically ill. Seven are in Atlanta, five in Savannah, two in Augusta, and there is one in Vidalia, Millen, Dublin, Keyesville, Thomasville, Valdosta, Quitman, Albany, Sandersville and Reeves. One home is for white men, two are for white women. Twelve are for white men and women. Five are for Negroes only. Two, both under the auspices of the Roman Catholic Church, receive patients without regard to sex, color or creed. Our Lady of Perpetual Help in Atlanta requires only for admission that the patient suffer from incurable cancer and be of sound mind. The other Catholic home and the two in Augusta are also free. In addition, there are some two hundred nursing homes that are run for profit. All of them should meet reasonable standards.

It must be emphasized that residents of homes for the aged or for the chronically ill are particularly prone to accidents and acute illnesses. Such homes therefore should have some medical supervision and should be near enough to a general hospital for patients to be transferred there when necessary.

Your Committee believes firmly that a person totally and permanently disabled with disease should be taken care of by his own relatives (if any) when he can receive adequate care in a home big enough to hold him and the other members of the family group. Under present day conditions, however, often this is not possible, and therefore there is need for additional beds for the care of the disabled, preferably in the neighborhood of their old homes.

In conclusion, your Committee would invite your attention to Dr. Eustace Allen's fine paper, "Longevity," read before this Association last spring: Dr. Allen emphasized the importance of routine physical examinations

of the middle-aged in order to detect conditions that may be cured or gotten under control before they become disabling, and the importance of encouraging those growing old to develop interests and hobbies and to remain self-sufficient and independent as long as possible.

The Report was referred to Reference Committee No. 1.

SPECIAL COMMITTEE ON THE CRAWFORD W. LONG MEMORIAL

Frank K. Boland, Chairman

Chairman Frank K. Boland of the Special Committee on the Crawford Long Memorial was called on by the Speaker for the Committee's initial Report, which was essentially as follows:

This committee was appointed from the Medical Association of Georgia, at the request of the Georgia Historical Commission, to advise as to a suitable memorial to be erected in Jefferson, Georgia, as a tribute to Dr. Crawford W. Long, and to have the care and operation of such memorial after its erection. The Georgia Historical Commission is charged with selecting historical spots in the State and marking them with appropriate memorials. The site of the discovery of ether anesthesia, in Jefferson, March 30, 1842, by Dr. Long, a member of this Association, has been chosen as one of these historical spots to be honored and commemorated.

The Georgia Historical Commission consists of the following members: Harry A. Alexander, Atlanta, Chairman; Joseph B. Cumming, Augusta; M. L. Fleetwood, Cartersville; Dr. A. R. Kelly, Athens; and Alex A. Lawrence, Savannah.

The site of Dr. Long's office, on the public square in Jefferson, now occupied by a two-story brick store building, on a lot 25 x 60 feet in size, has already been purchased by the Commission, at the price of \$5,000, the State of Georgia paying half of the amount, and the city of Jefferson paying the remaining half.

The Commission has asked that the Medical Association of Georgia give for ten years \$1,000 per year for the upkeep and operation of such memorial as shall be determined by the committee from our Association, after consultation with the citizens of Jefferson. The kind of memorial or shrine to be erected has not been decided upon definitely, but it is agreed that it should be in keeping with the magnitude of Crawford Long's discovery, probably with an imposing marble front, and a museum containing mementoes and relics of Dr. Long and his life and work, with a library and as many of the documentary proofs of the priority of the discovery as can be found.

The meeting of the Council of the Association, in Atlanta, last January, was attended by Mr. H. A. Alexander, Chairman of the Historical Commission, and a committee of citizens from Jefferson. These gentlemen, and others explained these plans, and asked that the Council recommend the granting of this gift of \$1,000 per year for ten years, to be approved at the present meeting of the House of Delegates. The undersigned committee was appointed, held a meeting in Jefferson on March 30, 1953, and now asks for your favorable action on the recommendation of the Council.

In the 111 years which have passed since the epochal achievement of the Georgia country doctor, Crawford Long, this is the first time the Medical Association of Georgia has been asked to give anything toward perpetuating the memory of his name and unsurpassed contribution to human welfare. Statues and other memorials have been put up by individuals and groups but never anything by this Association. If this donation is approved by you, it is the belief of Chairman Alexander that an amount of \$25,000 will be assigned to the building of a memorial of which we may be proud. The Commission already is spending this amount on Indian mounds in Georgia, and expects to give a similar amount to the restoration of the famous Vann House near Chatsworth. Not many months go by but some magazine article or radio or television program tells the world that someone else besides Crawford Long discovered surgical anesthesia. The proposal we present today offers an opportunity to combat such false propaganda, and help establish the truth.

The Report was referred to Reference Committee No. 1.

REPORT OF SUB-COMMITTEE ON HOSPITALS OF THE PUBLIC HEALTH COMMITTEE

R. F. Spanjer, Chairman

The Subcommittee on Hospitals of the Committee on Public Health was activated on 12-4-52. Subsequent meetings of the Subcommittee with Medical Association of Georgia officers and with members of the Division of Hospital Services of the Georgia Department of Public Health resulted in the following plan of action.

It was felt that those problems pertaining to small hospitals were most pertinent and that an investigation and integration of those matters which concern the administrative, medical, and nursing personnel should be considered as paramount. Thus programs are being planned in conjunction with the several district Hospital Council Meetings to present well organized seminars by competent hospital administrators, medical chiefs of staff and nursing supervisors concerning their mutual problems. The hospital administrators, medical chiefs of staff and nursing supervisors of all the hospitals in the respective Council Districts will be urged to participate in these seminars.

Specialists in their particular fields from the Department of Public Health, the Medical Association of Georgia, the Nursing Association, and others will act as consultants at these meetings.

It is anticipated that the Medical Association of Georgia will in this way sponsor the elimination of certain specific problems and facilitate cooperative integration of all personnel in producing optimal function of the small hospitals.

The Report was referred to Reference Committee No. 3.

AMA DELEGATES REPORT

The Speaker then called for the Annual Report of the Association's official two delegates to the American Medical Association, presented, as follows, by Charles Richardson, Sr.:

The House of Delegates of the AMA met in Chicago from June 9th to 13th, 1952. The first thing on the program was the address of the speaker, Dr. Borzell, and he showed that the average age of the membership was 59 years and that the average length of service in the House is 5½ years.

The next thing on the program was the Distinguished Service Award and this was voted to Dr. Paul Dudley White of Boston.

The president, Dr. Cline, in his address said that 85 million Americans now have hospital insurance, 65 million have surgical protection and 28 million have both medical and surgical protection. He felt that a strong and successful voluntary insurance program is our greatest bulwark against the socialization of medicine. He stated further that President Truman's commission on the Health Needs of the Nation was designed and appointed for political reasons and no other. Later in the program a resolution to consider this matter was tabled and the motion to table was seconded by Dr. Eustace A. Allen. Finally a resolution condemning the purposes and acts of this commission was adopted.

Then there was a resolution from the Board of Trustees stating that we believe the intrusion of the Federal Government into the field of education carries with it grave dangers and this was adopted. They also stated that any overall plan of medical care for the American people is unwise and that the development of individual and county interest should be encouraged and stimulated in every way with the purpose of finding good medical care on the local level, and the financing of medical services as far as possible by private contributions and local taxation.

They also favored a Department of Health but oppose the transfer of the hospital system of Armed Forces and the Veterans Administration to a Federal Department of Health. This resolution also asked a clear congressional definition of the extent of the government's responsibility for furnishing medical care with particular reference to the treatment of veterans with non-service disabilities and the dependents of service personnel.

The Board of Trustees also went on record as opposing House Bill 7800 in the Federal Congress to amend Social Security Act because it provides that the Federal Security Administration should:

- a—determine what constitutes total and permanent disability and
- b—establish the proof necessary to prove permanent and total disability and
- c—provide where physical examinations should be taken and
- d—be authorized to prescribe the examining physician or agency.

There was also an effort to hurry this bill through the Congress without proper debate or examination. Final act on this was taken on a substitute motion offered by myself that the A.M.A. urges that Congress re-refer this Bill to the committee where it should be subject to the ordinary democratic processes of legislation. This was seconded and carried.

It was brought to the attention of the House of Delegates that the effort of the International Labor Organization to set up minimum standards of health and medical care and get them adopted in this country by treaty arrangement is another effort to slip a scheme of socialized medicine in the back door. The A.M.A. went on record as favoring an amendment to the Constitution of the United States which will provide that no treaty or executive agreement shall be made which conflicts with any provisions of the Constitution or which may operate to regulate any of the purely domestic affairs of the United States and to that end endorses the Bricker Resolution in the National Congress.

The next matter to come before us was the report of the American Medical Educational Foundation. It showed that in the first year we raised \$745,000 among ourselves and this plus gifts from business and educational associations reached a total of \$1,600,000. A gift of \$10,000 of this amount came from the Woman's Auxiliary of the A.M.A. This I think deserves our highest praise. This money was granted on an average of \$20,000 to each school in this country.

Then was presented a resolution from the State of North Carolina asking that the old North State Medical Society, the State Organizations of Negro Physicians be admitted as a constituent association of the A.M.A. This was denied on the grounds that the by-laws of the A.M.A. state only that active members of constituent associations may become members.

The committee on Medical Military Affairs approved all resolutions condemning certain Veteran Administration practices such as the treatment of non-service connected disabilities but suggests that it requires further study and recommends that the whole matter be referred to the Board of Trustees for such purpose. This was adopted.

Atlantic City was selected for the meeting place of the 1955 session.

Dr. Edward J. McCormick of Toledo, Ohio, was elected president for 1954 and Dr. Leo Schiff of New York was elected vice-president.

The second meeting of the House of Delegates of the American Medical Association was held at the Clinical Meeting in Denver, Colorado, December 2nd to 5th, 1952.

The first thing on the agenda was the election of the General Practitioner of the Year and this honor fell to Dr. John Travis of Jacksonville, Texas. Our own Dr. C. A. Sharp had been nominated for this honor.

It was announced that Dr. Allen Bunce had been made a member of the new five man advisory committee to the Board of Trustees. This is quite an honor to both Dr. Bunce and our association.

The Board of Trustees reported a gift of a half million dollars in 1952 to the American Medical Education Foundation.

It was brought to the attention of the House that the Specialty Boards were too exacting and to that end a committee was appointed to study the matter of a period of general practice as a requisite for speciality certifications.

It was reported that 61 out of 79 medical schools have chapters of Student American Medical Associations.

The House went on record as opposing ratification by Congress of treaties made by International Labor Organization and to that end endorses the Bricker Resolution before Congress and also approved withdrawal of the United States from the I.L.O.

The delegates went on record as approving a Department of Health within the Federal Government with Cabinet status.

It was reported that three new medical schools have been created and there are 6715 registered hospitals in the United States. New essentials of intern training were approved and

published in the *Journal*.

Also a committee was appointed to undertake a comprehensive study of nursing care and nursing in this country and report to the next meeting in June of this year.

It was recommended that the name of "Grievance Committee" be changed to "Public Service Committee."

A resolution was approved opposing the payment of a percentage of doctors fees to hospitals in which they practice.

Another resolution was approved asking that separate bills be rendered by all M.D.'s participating in the treatment of a case.

The Board of Trustees was asked to give some consideration to the establishment of a Bureau at Headquarters to study the relationships between Doctors and Lay associates.

The Military Affairs Committee approved a resolution that the Armed Forces take classes one and two first in the Doctor Draft then three and four.

It approved a special pay for Medical Officers.

It then went on record as opposing the Veterans Administration care of non-service connected disabilities and suggested further study of the Army Medical Corps taking care of dependents of service men and also Veterans care.

A special called meeting of the House of Delegates of the American Medical Association was held in Washington, D. C., on March 15th, 1953. The call was issued by the Officers and Board of Trustees to hear an address by the President of the United States and to consider a recommendation of the Board of Trustees. This was the first time that this body had ever been accorded such an honor.

The House was called into special session to consider and pass on an executive order of the President of the United States which would combine the Federal Security Agency with the Departments of Health and Education into a Department of Health Education and Welfare with Cabinet status. This had already been considered by the Board of Trustees and came as a recommendation with their approval.

After a fair amount of discussion the House of Delegates of the American Medical Association voted unanimously in favor of this plan with the reservation that if it should not prove satisfactory we could again raise the issue of a separate Department of Health.

The plan provides for an assistant to the Secretary who it is understood will be an M.D. and that all health matters will be cleared through him.

A.M.A. Delegates Richardson and Allen then presented the following three resolutions, requesting House approval for presentation to the A.M.A. House of Delegates at the June Session in New York City:

BE IT RESOLVED: 1—That the House of Delegates of the Medical Association of Georgia go on record as being opposed to the general principle of the treatment of non-service connected disabilities by the Veterans Administration.

2—That the House of Delegates of the Medical Association of Georgia endorse the position of the A.M.A. in forming an amendment to the Constitution of the United States which will provide that no treaty or executive agreement shall be made which conflicts with any provision of the Constitution or which may operate to regulate any of the purely domestic affairs of the United States and to that end endorses the Bricker Resolution in the national Congress.

3—That the House of Delegates of the Medical Association of Georgia endorse the action of the House of Delegates of the A.M.A. in approving the action of the Federal Government in combining the Federal Security Agency with the Departments of Health and Education into a department of Health Education and Welfare with Cabinet status.

The Report was referred to Reference Committee No. 4.

REPORT OF THE AUXILIARY PRESIDENT

Mrs. Ralph W. Fowler

How I wish for a fairy wand that I might depict for you a complete picture of the past year's activities and many accomplishments of the Woman's Auxiliary to the Medical Association of Georgia!

As we approach our twenty-ninth year since organization, our basic object, friendly relations, is as paramount as ever, but our activities have so broadened that our present objectives encompass boundaries far beyond the vision of our founders.

Dr. Holton, president of the Medical Association of Georgia, appointed as our advisory committee, the five immediate past-presidents, one of whom passed away soon after convention. I would like to pay tribute here to Dr. Edgar Hill Greene. He was a true friend of the auxiliary and one whom we shall continue to miss.

We met with our advisory committee in June, to present, and have approved, our plans for the year. We chose for our theme of the year, "WORKING TOGETHER FOR HEALTH AND FREEDOM." Through our efforts, we have reaped the benefits of warm friendships and stronger bonds within the profession. Our accomplishments include public service, information, community participation, new friends made for medicine and its objectives, and money for scholarships. As our activities and objectives have increased, so have our responsibilities.

Believing the individual member to be our most valuable asset, much emphasis has been placed on membership. The membership chairman, the member-at-large chairman, and I, together with our capable managers of the ten districts, have joined in a united effort with county presidents to enlist the membership of all physicians' wives who are eligible. Our efforts were rewarded with a gain of 1300 new members and five new auxiliaries, which are: Coffee, Chattooga, Spalding, Thomas and Calhoun-Early-Miller.

Perhaps this has been one of our busiest years in Legislation. Mrs. Evert Bancker, our chairman, has worked hard to keep our membership informed on government health plans. Several auxiliary members attended the one-day session of the A.M.A. sponsored Legislative Conference, held in Jacksonville, for Georgia and Florida, on October 15. After studying the issues at stake in the forthcoming election, the chief job seemed to be in getting out the vote, which we set out to do. One county president reports 50 hours at the telephone, getting block leaders. We hope that never again can it be said that only one-third of the medical population voted in a general election. The results of the November election is evidence of how our members joined forces with others over the nation in getting out the vote. It has been our plan this year for each legislative chairman to be allotted some time at each meeting in which to post the membership on medical legislation. We have tried to keep informed so that we could support those bills considered by the profession to be good for the people, and to defeat those opposed by the medical association. We were represented at the state capitol when a professional license bill was being discussed in committee. Some of our members entertained their congressman, and Fulton County entertained the wives of the law-makers at one of their interesting luncheon meetings, while legislature was in session.

Mrs. Murdock Equen, program chairman, reports that most of the auxiliaries have had well-planned, interesting and stimulating programs, all in the field of health. Many have had open meetings with good speakers, to which the public was invited.

Mrs. Edgar Dunstan and Mrs. Shelly Davis, co-chairman of Civil Defense, report that almost every county Auxiliary has been busy taking and teaching courses in Home Nursing and First Aid. Richmond County planned a splendid program on Civil Defense, inviting the public to participate. In this way the medical auxiliary was said to have provided the springboard for Civil Defense in the county. Bibb County also had a big, successful open meeting on Atomic Warfare. Other counties active in Civil Defense were, Fulton, Cobb, Muscogee, DeKalb, Glynn, and Gwinnett. Several members are serving on Community Planning boards throughout the state. I have served for more than a year on the state executive committee of five, to plan and co-ordinate Georgia Women's activities in Civil Defense.

Mrs. Truman Whitfield, Jr., reports that Carroll-Douglas-Haralson sponsored an essay contest on Research and Romance. This created much interest in the three counties and rated good publicity. Through this, several splendid biographies were obtained for our files. Several other groups have contributed papers to the Research and Romance Library, helping to perpetuate the lives of many great men of medicine.

With the idea of making available, papers suitable for programs on various phases of Health Education, we have begun this year a new project, Liberty Service, which will become more complete as time goes on, making it a valuable

asset to the auxiliary and to the public. Mrs. J. Harris Dew, chairman, reports that Chatham County has formed a Speakers Bureau with informed members available for talks on Voluntary Health Insurance.

In Georgia, we are perhaps, more aware of Doctor's Day than those of other states since the idea was born here and commemorates the date when Dr. Crawford W. Long first used ether anesthesia in Jefferson, Georgia, March 30, 1842. It makes us happy to know that this Georgia idea of paying tribute to the medical profession, took wings and Doctor's Day is now celebrated in all states, Hawaii, and Alaska. From Mrs. L. W. Williams' report it would seem that each auxiliary in our state tried to out-do all others in their Doctor's Day celebration of 1953. In addition to the wonderful parties, dinners, dances, costume balls, barbecues, picnics, hobby shows, etc., all medical men were adorned with red carnation boutonnières. Every town with an auxiliary displayed beautiful posters depicting The Modern Doctor. The poster was designed by Dr. and Mrs. Ted Leigh, and financed for us by M.A.G. Most auxiliaries also arranged for the movie short, "Your Doctor," to be shown in the local theater. Many editorials and other publicity, paying tribute to the physician appeared in the newspapers. Bibb County reports a proclamation of Doctor's Day from the mayor of Macon.

Mrs. D. L. Wood reports 177 subscriptions to the national bulletins, an increase of 34. The *Today's Health* chairman, Mrs. R. C. McGahee has worked hard to circulate this excellent health publication, which is such a good media of Public Relations. With subscriptions still coming in, our total is 616. This, while far from our goal of two per member, is a substantial gain of 164 over last year. In National Competition, Cobb County rated 303 per cent, while Richmond County was 8th in the nation for an auxiliary of its size. Cherokee, and Pickens rated 200 per cent, Gwinnett placed it in all schools and Worth placed it in libraries.

In response to a request of the medical profession, we have mapped an extensive nurse-recruiting program. Future Nurses of America Clubs have been organized in the high schools, films on nursing have been shown, and high school seniors were taken on hospital tours to see nurses in action. Films on nursing were also shown to high school girls hoping to encourage them toward a nursing career. Several groups, by silver teas, white elephant and bake sales, TV and fashion shows, raised money toward scholarship funds for nurse-training, according to the chairman, Mrs. Eustace Allen.

We maintain a loan fund for medical students, total assets of which are, \$8,669.80 with two outstanding loans. Since the recent enactment of a state law, enabling medical students to borrow from the state for their medical education, we will probably find it necessary to make some changes in our loan fund policy. The chairman, Mrs. Shelley Davis, says that no new loans have been made this year.

All auxiliaries report a great amount of community participation in health services. We have been most active as presidents, and health, public relations and legislative chairmen in important Women's organizations.

The American Medical Education Foundation is a new project this year. Mrs. Walker Curtis, P. R. Chairman, reports that though begun late, several auxiliaries responded to this very worthy cause, with contributions of various amounts. Richmond County gave a contribution in honor of Dr. Lombard Kelly a favorite Georgia doctor who is retiring as dean of the State Medical School. Worth County, one of our newest auxiliaries, also made a contribution as did Chatham, Glynn and Fulton. We realize this is an effort devised by the medical profession to prevent the government subsidizing the cost of medical training.

In an effort to combat the ever-increasing threat of socialism which seems to be infiltrating American institutions of learning, we have been urged to promote the AAPS sponsored contest. The title, "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care," is a positive approach to the problem of compulsory health insurance. Our efforts in this project have met with some opposition from the executive board of the High Schools of Georgia, which failed to approve the contest, thereby making it impossible for many schools to enter. However, there were about 85 entries, with Richmond, Muscogee, Habersham, Gwinnett, Whitfield and Cobb participating. The judges awarded the three prizes donated by the M.A.G.—\$100, \$50

and \$25 for first, second, and third respectively. Muscogee County won first and second, while Richmond won third prize.

These winning essays were sent on to be judged in national competition for the prizes of \$1,000 downward. The true value of the contest lies in the lesson in free enterprise and true Americanism obtained from the reference material placed in the school libraries by the auxiliaries. It is believed that the opposition which has arisen will only serve to challenge our efforts in a public relations job that is even bigger and more essential than we had formerly realized. I would like to recommend a continuation of the contest next year, subject to approval of the High School Association of Georgia.

Many new projects such as the Kennestone Hospital Gift Shop of Cobb County, the Cancer Loan Chest of Richmond, renovation of a portion of Chatham County Children's Home into a Clinic, the Crippled Children's Clinic of Crisp County, Muscogee's Mobile Libraries, Baldwin's Health Survey, Chatham's Rheumatic Fever Survey, Fulton's TV and radio shows and Fashion Show to raise money for nurse scholarships, and others which we hope will be a distinct contribution to the health and welfare of the state, have been presented. In a final analysis, all these add up to a splendid job in the field of public relations.

It is a source of pride that the auxiliary is gaining more recognition from the profession. One of our members, Mrs. Shelley Davis, was asked to speak on the program of the first Medical Public Relations Institute of AMA Legislation Conference held in Chicago. The Auxiliary was invited to participate in the AMA-sponsored Georgia-Florida Legislation Conference in Jacksonville in October. We were asked to send representatives to the state capitol when a professional license bill was being discussed in committee, during recent legislature. As president, I was invited to address the First Annual Conference of Presidents and Secretaries of MAG on February 22 in Atlanta. The county medical societies have come to depend more and more upon their auxiliaries.

In compliance with a request from Dr. Henry Poer, Association Secretary, Mrs. Olin Cofer is heading a committee collecting photographs of all past presidents of the Medical Association and its auxiliary, to be placed in the Hall of Fame at state headquarters.

A committee headed by Mrs. Ralph McCord and Mrs. Braswell Collins was appointed at our first board meeting, to revise awards, the outcome of which was the Award of Excellence. A point system was devised which makes an available yardstick, to aid in measuring the achievements of each county toward this award, which embraces all phases of auxiliary program.

We are especially grateful to the Medical Association of Georgia for again making it financially possible for us to have had four attractive issues of *Auxiliary News* during the year. This media has been invaluable in presenting annual plans, in keeping the membership informed on plans of the state and national conventions. We are deeply grateful to Mrs. Ben Hill Clifton, who has edited this publication since its inception two years ago.

Mrs. R. W. Bradford reports that our camellia garden on the grounds of the state hospital in Milledgeville, is becoming more beautiful each year, with the addition of several new plants from time to time.

Perhaps the auxiliary's greatest potentiality is in public relations. Every doctor's wife, whether or not she intends to be, is a public relations agent for the medical profession. Therein lies the value of being a well informed auxiliary member. We have an extensive program designed to make friends for medicine. How we wish the public knew the physician as we know him! Through the chairmanship of Mrs. Walker Curtis we have endeavored to help the medical association continue their liaison, letting the public know more of the practice of medicine as it is under the present status of free enterprise. With this in mind, we have participated in the Georgia Products Spring Festival. While others are showing what the state has in industry, agriculture, etc., we attempted to show what Georgia has to offer in health by holding open house in hospitals, clinics, and other health agencies. Mrs. C. C. Aven, Chairman of this project, reports that Bibb and Ware were among those participating.

Looking back quickly over the year, my official state activities include the executive board meeting with the advisory committee and the School of Instruction, held in

Macon on June 23; meeting with county presidents at the Medical Academy on September 5; AMA Legislative Conference in Jacksonville on October 15; Chicago Conference for Presidents and President-elects in November, at which time I served as secretary of the conference; the Southern Medical Convention in Miami in November; Executive Board Meeting in Atlanta on January 23; the MAG Conference for Presidents and Secretaries in February when I addressed the physicians and national representatives on "The Aspects of the Auxiliary and What it Means to the Profession;" and the Pre-convention Board Meeting in Savannah May 10. I have also attended and addressed ten district meetings over the state and 25 county auxiliaries and have helped to organize five new auxiliaries. I represented you at five meetings of the Executive Board of the Better Health Council during the past year and the same number during the preceding year; made a visit to the state capitol in the interest of medical legislation; attended five meetings of the state executive Civil Defense Committee of five to plan and coordinate women's efforts in Civil Defense throughout the state. My duties included many trips to MAG headquarters. I talked to several lay groups, recorded two radio scripts, wrote about 1,200 letters and approximately 400 postal cards, made numerous telephone calls, and sent many telegrams. My work was greatly facilitated by my able and efficient corresponding secretary and neighbor, Mrs. John F. Busch, Jr.

We are very grateful to Dr. C. F. Holton, president of the Medical Association of Georgia, who, through his interest and wholehearted cooperation, has endeared himself to the auxiliary membership; to Dr. Henry Poer, Secretary, who has been our friend in every instance, and who is to be congratulated for the splendid progress he is making for the association; to Mr. Sid Wrightsman, whose sound advice, guidance and assistance makes auxiliary progress possible; to Mr. Milton Krueger, managing editor of the *Journal of the Medical Association of Georgia*, for his cooperation and help on our publication; to the office personnel, Miss Thelma Franklin, Margaret Meadows and Myrtice Mulligan all of whom so pleasantly cooperated during my term of office.

A vote of thanks goes to Mrs. A. H. Letton, Mrs. Ted Leigh, and Mrs. Murdock Euen for their able assistance in compiling and arranging our first year-book for reports.

I would like to give special commendation to one who has given me the understanding and encouragement I needed to go on this past year and to whom the auxiliary owes a debt of gratitude—my husband, Dr. Ralph Fowler.

It is not possible to mention all the committees, auxiliaries, and individuals who have contributed so much to the success of this year's program. I have tried to point out how programs inaugurated in previous years, have been carried out with increased vigor. The full cooperation and wise council of my predecessor, Mrs. J. R. S. Mays, enabled me to follow through the auxiliary program with continuity, in an effort to increase the great achievements of previous years.

Since the accomplishments reported here, reflects credit upon the officers, chairmen, and members of the auxiliary, and not upon the president, I take pride in making this report, expressing in it, sincere appreciation for loyal cooperation that has brought this year to a successful completion.

RECOMMENDATIONS

1. Workroom and facilities (desk, typewriter, files, etc.) and some part-time stenographic assistance, available in headquarters office to relieve existing staff of miscellaneous inconvenience.

2. Continuation of financial support from MAG.

\$600 for publication, Auxiliary News.

\$250 for travel expenses of president and president-elect to annual Chicago Conference.

\$175 for Essay Contest prizes (subject to approval of High School Association of Georgia).

Mrs. Fowler's Report was referred to Reference Committee No. 2.

BETTER HEALTH COUNCIL REPORT

Mrs. Shelley C. Davis

The Speaker then requested Mrs. Shelley C. Davis to report on activities of the Better Health Council of Georgia. Mrs. Davis spoke essentially as follows:

"Mr. President, Chairman, Members of the House of Delegates, Guests:

"It is a privilege to report to you from the Better Health Council of Georgia.

"It was only five years ago that your own Dr. Steve Kenyon and Dr. Ed Greene went to the Governor of Georgia and asked his assistance in bringing together one hundred representative citizens of Georgia to organize a Health Council in this state.

"Then, as now, the doctors had a terrific message to bring to the lay people. The very existence of medicine, as we know it in our free world hung in the balance. Then, as now, there was the press, the local county societies contacts and some public appearance when the individual physician could take time from his practice, but it was not enough to combat the menace of socialized medicine.

"Some organized effort was necessary in Georgia not only to tell our people the truth about such a sugar-coated pill but also it was a time to begin some *real* public relations by showing a spirit of cooperation, a willingness to sit down in conference with the mayor, school superintendent, city councilmen, P.T.A. women's clubs, civic and service club members and the ministers at the grass roots level and discuss health problems most important to them in their own community; to tell them where and how medical care and health services were most available and above all that health is everybody's business. The man in the street had to realize then as now there was a way to make his personal needs known and appreciated without a professional call from his personal physician.

"The Health Council was enthusiastically organized by our laymen with the leadership of the Medical Association of Georgia. The Governor offered office and staff from a tax supported agency and a great program was launched. In 1951 the State legislature cut appropriations and the Health Council was without funds. Again our doctors felt that private financial support would free the council from any political connections and in no other way could the member health agencies and organizations find so cheap a way to organize and execute local and regional meetings to bring their programs down to the people. At no other time had the public Health Department, the Dental Association, the Heart Association, the Cancer Society, Tuberculosis Association, Crippled Children's Society, the Nurses Association, the Polio Foundation, Pharmaceutical Association and many others sat down with our doctors to plan and coordinate activities. The cost of getting to the local people could be shared by all individual organizations instead of each going to the expense of building its own conferences.

"From then on you know the story. Dr. Enoch Callaway led out with a \$1,000 from the Cancer Society contingent upon other groups contributing funds. \$7,400 of the \$10,000 a year budget was raised and so a part time executive secretary with a full time office secretary and office space donated by the Fulton County Medical Society are now in operation along with 25 local health councils which the State Health Department as an arm of the government was not in a position to organize.

"The six regional conferences have progressed in rotation with the annual statewide meeting last September with every one of Georgia's 159 counties participating. Seventy-five per cent of the attendance has come from laymen of Georgia grasping at the opportunity to meet and receive authentic information from our professional personnel. The mailing list soars into the thousands with request for programs and health material bombarding the office.

"The first directory of Health Agencies and organizations in the state has been compiled and stands ready to go to press.

"A quarterly news bulletin to be mailed to approximately 6,500 citizens in the state awaits printing and postage.

"Each county library in the state is now prepared to set up a health information shelf as the Better Health Council supplies approved literature.

"Television programs are allotting gratis time on the air to the Health Council.

"Many of you have already participated in the tape recordings for distribution to local radio stations all over the state.

"The Georgia legislature has granted every request for public hearings on health bills that came from this laymen's organization with the Junior Chamber of Commerce heading the legislative committee.

"Requests for doctor placement in rural communities take on a more personal nature beyond professional qualifications

when they come to the health council.

"As the program grows more funds are needed. Are we to progress or must we stop here?"

"Can we keep the leadership under the proper supervision or will we be forced to accept additional financial support from groups within the council that are known to be critical of our voluntary approach to medical care? For surely such an *entree* to the grass roots is a desirable medium for any labor movement or pseudo medical cult.

"Today the Council stands at this point of decision. We laymen earnestly seek your guidance and your concrete support.

"Will the Council live and go forward? And, if so, which of the many divergent groups will support and direct its thinking. The opportunity of choice is yours at this point. It is a decision worthy of your serious consideration."

The Report was referred to Reference Committee No. 1.

NEW BUSINESS

Speaker Goodwin then called for introduction of new business.

Charles T. Cowart, Troup County Medical Society, presented the following resolution:

"BE IT RESOLVED, That the Troup County Medical Society is opposed to the practice of transacting society business or the holding of any official meetings of any kind by the societies or associations on Sundays. Be it further resolved that the Troup County Medical Society delegate be instructed to submit this resolution to the House of Delegates of the Medical Association of Georgia for action at the time of the annual meeting in May, 1953, and that a copy of this Resolution be sent to the Secretary of the Medical Association of Georgia."

The resolution was referred to Reference Committee No. 2.

J. H. Patterson, Fulton County Medical Society, submitted the following resolution:

WHEREAS, Carefully controlled studies have demonstrated that fluoridation of water supplies has been definitely beneficial in the reduction of dental caries, and

WHEREAS, The Councils on Pharmacy and Chemistry of the American Medical Association has reported that fluoride in recommended amounts is non-toxic in community water supplies, and

WHEREAS, The addition of fluoride to water supplies has been endorsed by the American Medical Association, American Dental Association, United States Public Health Service, State and Territorial Health Officers Association, Georgia Dental Association, Georgia State Board of Health, and others as both effective and safe; now, therefore be it

RESOLVED, That the Medical Association of Georgia endorse the principle of fluoridation as a means of reducing dental caries and recommend that communities which have water supplies free from or low in fluorides consider the feasibility of adjusting the fluoride concentration to the optimum level, not to exceed one part per million.

The Resolution was referred to Reference Committee No. 3.

Lester Rumble, Fulton County Medical Society, submitted the following resolution:

WHEREAS, Certain veterans' hospitals have demonstrated a definite policy of accepting non-service connected disability cases among veterans; and

WHEREAS, A recent survey of one such hospital disclosed that approximately 80% of the patients had no service-connected disability; and of those signing pauper's oaths at least 25% obviously had adequate financial resources, and

WHEREAS, Such policy constitutes an unjust burden on the taxpayer and reduces the number of beds available for service-connected cases,

BE IT RESOLVED, That the Medical Association of Georgia go on record as approving the following policies:

1. That the best possible care be given all veterans with service-connected disabilities.

2. That the best possible care be given non-service connected disabled veterans who need financial support.

3. That veterans with non-service connected disabilities who are able to do so make provisions for their own care.

The Resolution was referred to Reference Committee No. 4.

A. H. Letton, Fulton County Medical Society, submitted the following resolution:

BE IT RESOLVED, That the House of Delegates of the M.A.G. approve the issuing by The Georgia Division of the American Cancer Society certificates showing physicians interest in the detection and treatment of cancer and further that they wish this program success.

The Resolution was referred to Reference Committee No. 4.

Charles M. Garland, Jr., Cobb County Medical Society, presented the following resolution:

WHEREAS, The Cobb County Medical Society in regular session at eight o'clock in the evening, May 5, 1953, in the Conference Room of the Kennestone Hospital, Marietta, Georgia, with more than two-thirds of the membership present voted and passed to have its delegates present before the House of Delegates at the Annual Meeting in Savannah of the Georgia Medical Association, May 10th, the problem of Insurance Fees as outlined in the Georgia Plan.

WHEREAS, The Cobb County Medical Society feels that where the patient is covered by multiple policies, one of them being on the Georgia Plan, each providing Surgical Fees—the total coverage being greater than that charged as the surgeon's usual fee. The Cobb County Medical Society feels that the surgeon should be allowed to charge his usual fee.

NOW THEREFORE, BE IT RESOLVED, That this Society has instructed its delegates to present these resolutions to the State House of Delegates asking that the present regulations be changed to conform with the insurance coverage of the individual as well as the income level as set forth by the Georgia Plan.

The resolution was referred to Reference Committee No. 1.

Fred H. Simonton, Walker-Catoosa-Dade Medical Society, submitted the following three resolutions for official House consideration, each representing action taken by the Congress of Delegates, American Academy of General Practice, March 23, 1953:

RESOLUTION 1:

WHEREAS, Dr. Paul R. Hawley, the Director of the American College of Surgeons, who lists his address as 40 East Erie Street, Chicago, Illinois, a general practitioner and not a member of the American Medical Association, recently was invited by the editors of the *U. S. News and World Report*, a lay magazine of national circulation and distribution, to their conference room, where there took place a certain interview appearing in the February 20, 1953, issue on pages 48 to 55, both inclusive, a true and correct copy of which interview is hereto appended as Exhibit A; and it appears that said interview consisted of many questions propounded to and answered by Dr. Hawley, on a variety of subjects touching the medical profession and the conduct of its members, some excerpts of which are as follows:

"Q. Is it your contention, Dr. Hawley, that fee splitting among doctors is wrong?"

"A. Fee splitting . . . results in a lot of bad surgery and a terrible lot of unnecessary surgery. . . ."

"Q. Does this ghost surgeon work by an X-ray? How does he know about where to cut?"

"A. Of course, he can have anything he may need for the operation, but nine times out of ten, no. He just takes the word of the doctor who tells him what he thinks is wrong."

"Q. He is like a butcher."

"A. A meat cutter. One of my friends likes to call them hewers of flesh and drawers of blood."

"Q. Is there any tendency toward abuse in those things? (Referring to fees in sickness funds)."

"A. On a wide scale, no, in isolated spots, yes. I don't know whether you have noticed it out in California or not . . . there have been 200 doctors out there who have been chiseling on the Blue Shield Fund. . . ."

Q. Isn't all this crusading against unethical practice in medicine going to undermine public confidence in physicians?"

"A. Yes, there is that definite reaction to expect. . . . My only answer to that would be that the profession has brought

in on themselves . . . ; and

WHEREAS, It appears that the answers of Dr. Hawley in said interview contain misstatements and distortions of fact, unfounded and uncorroborated charges, platitudes, innuendoes and generalizations with implications of a pernicious and unsavory nature, individual and collective self-laudation of grandiose proportions, and scurrilous and derogatory remarks tending to bring the medical profession in disrepute and to make it subject to public suspicion, ridicule and scorn; and

WHEREAS, In an "unprecedented meeting" of the board of regents of the American College of Surgeons, as reported in newspapers with national and international coverage on or about September 25, 1952 (see Exhibit B hereto attached), the regents asked the aid of newspapers—not of medical associations and forums—in educating the public to certain evils, four of the members being directly quoted on the subject; and that the same ideas with unqualified amplifications and ramifications were echoed by Dr. Hawley in his interview above referred to; and

WHEREAS, It further appears that Dr. Hawley in said interview, when asked about the selection of a doctor, replied ". . . if I had any choice . . . I would not allow anybody to go into my belly who was not a member of the American College of Surgeons or a diplomate of the American Board of Surgeons;" that he volunteered the statement that "We in the College of Surgeons investigate all possible unethical practice—unnecessary surgery, ghost surgery, fee splitting . . . ; that when questioned, "If a hospital has your certificate on the wall, would it be likely to do this type of surgery" (referring to ghost surgery), Dr. Hawley replied, "Oh, no. But we have given up our own certification;" and it appears that all said answers were self-laudations which "defy the traditions and lower the moral standard of the medical profession" and were deliberately designed to promote and elevate the American College of Surgeons at the expense of all in the medical profession who are not members of said College; and that in view of these public pronouncements and others of a similar vein, there exists a serious doubt as to whether the American College of Surgeons, whose representatives sit on the board for accrediting hospitals, can render an impartial and unbiased report in the performance of their duties; and

WHEREAS, The American Medical Association is the supreme voice and authority in all matters pertaining to and affecting the medical profession; that all other constituent organizations, being a part of the whole, cannot be greater than the whole, that the American College of Surgeons, through its director and regents, has attempted to arrogate unto itself vast powers which it does not possess and has held itself out as the palladin of medical virtue; that it would be catastrophic were other organizations within the American Medical Association, seeing this precedent of unbridled and unlicensed newspaper and magazine comments go unchallenged, to issue criminations and recriminations in airing of medical problems through the medium of lay publications, as a consequence of which there would be chaos and confusion of voices and as resultant the further undermining of public confidence in the medical profession; and it is therefore necessary that a thorough inquiry and review be made of this entire situation, a policy formulated and established and remedial measures adopted;

NOW, THEREFORE, BE IT RESOLVED, That the Congress of Delegates of the American Academy of General Practice recommends that the above conditions in the medical profession be presented to the various state chapters of the American Academy of General Practice and that these state chapters urge their members to present to their respective county and state medical societies the above report with a request for a thorough inquiry, review and remedial action at the earliest date; and

BE IT FURTHER RESOLVED, That the Congress of Delegates of the American Academy of General Practice recommends that the above report be transmitted in its entirety to the official of the American Medical Association at the earliest possible date for the institution of disciplinary action.

RESOLUTION II:

WHEREAS, The American Academy of General Practice realizes that ill-advised, unfounded, false, misleading and

vitriolic news releases or statements—such as the recent interview published in the magazine *U. S. News* by one who takes it upon himself to assume the role of spokesman for an honored and respected medical organization—can do infinitely more harm to an understanding between doctors of medicine and the American public than can be corrected by years of patient, thoughtful, and even considered effort; and

WHEREAS, The American Academy of General Practice, like all other organized groups of doctors, respects its position as a subsidiary or constituent of the parent organization of all medical doctors in the United States, viz., the American Medical Association; and

WHEREAS, The American Academy of General Practice seeks to take any steps necessary to assist in affecting a peaceful unanimity, rather than a cacophonous division, within the ranks of American doctors; and

WHEREAS, The American Academy of General Practice firmly, steadfastly and sincerely believe in the basic honor, both personal and professional, of the medical doctors of the United States; and

WHEREAS, The general practitioners of America neither have, nor desire to have a quarrel with any group of medical specialists, because among the specialty groups are many respected, honest and skillful men whom we summon for counsel and help; and

WHEREAS, The American Academy of General Practice believes that the recent unsavory pseudo-expose by the Director of the American College of Surgeons, forces upon the medical doctors of America an urgent necessity for the settlement of certain basic issues to prevent future assaults upon the honor, integrity and professional standing of general practitioners, and the entire medical profession; and

WHEREAS, The American Academy of General Practice believes this task can only be accomplished by and through the American Medical Association;

THEREFORE, BE IT RESOLVED, That:

1. The American Medical Association be asked to consider some means of controlling public expressions of its members which are:

a. Beneath the dignity doctors strive to attain for their profession.

b. Inclined or intended to cast aspersions upon, arouse suspicion against, or undermine the public confidence in any particular group within the medical profession.

c. Possible acts or attempts to unfairly gain preference for any one portion or group of doctors above another, because each group of doctors has its service to perform within the economy of medical practice, and such acts are too often the product of selfish motives. (See Chapter III, Article I, Sections No. 1 and No. 4, Principles of Medical Ethics).

2. The American Medical Association be asked to resist attempts by any group, or a spokesman for any group, to impugn the judgment of the general practitioner or other qualified doctor of medicine, in performing any service for which he is qualified.

3. The American Medical Association be asked to define explicitly a method by which joint or combined bills, covering the professional services of several doctors in respect of a single case, may be rendered to a patient or his legally authorized agent, or the insurance company for the patient, by one doctor, acting for himself and those other doctors who may be associated with him in treating the single case.

4. The American Medical Association be asked to actively and thoroughly distribute and disseminate to the American people information as to the attitude of the doctors in opposition to exorbitant fees, unnecessary surgery, ghost surgery, split fees, commissions and referral fees but, at the same time, to do all in their power to reassure the public that, although a single infraction of medical ethics is serious, still, such unethical practices are the exception rather than the rule, and that the doctors will make every effort to eliminate such unethical conduct as may exist.

5. The American Medical Association be enjoined to more adequately disclose through its public relations media the functions of a medical doctor, expand the understanding of uninformed people of doctor-patient relationships and ethics, and take steps to strengthen any programs for improvement of the understanding by doctors of doctor-patient relationships;

BE IT RESOLVED, THAT:

1. A copy of these resolutions be forwarded to the proper officers of the American Medical Association and that said officers be requested to refer them to the appropriate committees, commissions, or councils of said association for study and action; and

2. The officers of the American Medical Association be respectfully requested to advise the President or Chairman of the Board of Directors of the American Academy of General Practice in respect to the disposition and action taken, after the consideration by the American Medical Association; and

3. The President or Chairman of the Board of Directors of the American Academy of General Practice shall report back to the Congress of Delegates, at its next annual meeting, what shall have occurred in respect hereto.

RESOLUTION III:

WHEREAS, The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration; yet the matters of fees, collections and statements must be covered. The decision as to the ethical or unethical nature of practice must be based upon the ultimate effect for good or ill on the patient as an individual and the public as a whole; and,

WHEREAS, With the increasing development of medical skill it has become more and more frequently necessary for two or more physicians to participate in the care of the patient; and

WHEREAS, It is also a known fact that for the welfare of the patient, two or more doctors must be present at surgery in the event of the disability of any one of them during the operation, or in an emergency, and this is a requirement in many hospitals' rules and regulations; and,

WHEREAS, The medical profession has been governed since time immemorial by a code of ethics which safeguards the best interests of the public; and,

WHEREAS, This code is phrased in general terms which do not desire specific procedure; and,

WHEREAS, In many communities it has been common practice for the general practitioner or family physician and/or another physician to participate in the medical and surgical care of the patient, with the family or patient in many instances requesting the family physician to be present at surgery and in the care of the patient; and,

WHEREAS, The general practitioner is eminently qualified to secure for his patients the best medical or surgical consultation available, and thereby discharge a prime duty to his patients; and,

WHEREAS, This cooperation between the general practitioner and the limited practitioner has been accepted and approved by many communities as a community practice conveying definite benefits to the community, and has received community approval as being in the best interest of the patient; and,

WHEREAS, The patients and the public have accepted and approved the joint activities of doctors of medicine upon individual cases involving surgery, or in cases involving diagnosis and treatment only, all to the benefit of the patient, and,

WHEREAS, In many communities there have been joint activities by doctors of medicine, and one bill rendered therefore, with the consent, expressed or implied, of the patient, or his legal representative, one physician acting as agent for the other. Physicians and surgeons have, in their activities of rendering joint services to the patient with the patient's consent, collected the fee on one statement and have thereby fulfilled their plain and palpable duty to their fellow men and have had due regard to all of the circumstances of each particular situation and relation; and,

WHEREAS, In many instances, patients have expressed their own desire for one bill, the payment of the bill at one place, and so by custom it has become an accepted practice in many communities; and,

WHEREAS, Public policy is the community common sense and common conscience extended and applied throughout the nation to matters of public morals, public health, public safety, public welfare and the like, therefore be it

RESOLVED, That the following definitions, policies and procedures, for purposes of clarification, be hereby again restated and adopted and approved by the American Academy

of General Practice and that such clarification be brought to the attention of the A.M.A. for their restatement, adoption and incorporation in the Principles of Medical Ethics of the A.M.A.; and be it further

RESOLVED, That the American Academy of General Practice transmit this clarification to all state chapters with the directive that such state chapters shall enter this as a Resolution through their respective county and state medical societies for final transmission by their instructed delegates to the A.M.A., and that a copy of this resolution be submitted to the Board of Trustees of the A.M.A.:

1. Definitions of Terms:

A. Fee Division or Divided Fees: An ethical sharing of fees between two or more physicians for active participation in the medical and/or surgical care of a patient with the expressed or implied knowledge of the patient.

B. Fee-Splitting or Split Fees: The American Academy of General Practice defines fee-splitting as any division of fees for services of physicians without the full knowledge of the patient.

C. Kick Back, Rebate, Commission, Forwarding Fee: A fee, preferment or gain, accepted by a physician from a lay person, another physician, or a corporation, for referring, directing or recommending a patient to them for services or supplies.

D. Ghost Surgery or Ghost Medicine: A device or scheme whereby surgical or medical services are performed by a physician other than the physician the patient has been led to believe would perform these services.

2. In legal partnerships of doctors, or clinics of doctors, or where doctors have joined together in the practice of medicine, and so hold themselves out to the public and patients, where all income and expenses are joint account or joint venture, it is ethical and legal for the members of the group to confer and care for a patient and to render one bill to the patient, and the income shall be divided in accordance with their contract basis or salary or percentage arrangement.

3. When two or more doctors actually and in person, render services to one patient, and the doctors desire to submit one statement to the patient, for the services rendered, it should be made clear to the patient or his legal representative that this is to be divided equitably among all physicians who have rendered services, and the patient's consent, either express or implied, obtained as to such procedure. It is ethical and legal to render one bill, and this fee may be paid in its entirety to either physician, and the one receiving payment shall forward the other his fee.

4. Each physician may, if he so desires, render to the patient an individual bill for his individual services, rather than the procedures elaborated above.

The three resolutions were referred to Reference Committee No. 2.

C. J. Wyatt, Jr., Floyd County Medical Society, read the following resolution:

WHEREAS, The Secretary and Treasurer of the Medical Association of Georgia has been outstanding in the performance of this duties and much progress has been made in the organizational activities of this Association during his term of office, it is hereby resolved that Dr. David Henry Poer be highly commended for his accomplishments.

The resolution was referred to Reference Committee No. 1.

Virgil B. Williams, Spalding County Medical Society, presented the following resolution:

WHEREAS, Under the present setup of the Georgia Plan, as we understand it, there exists no provision for remuneration for services of a surgical assistant. Therefore, be it resolved that the Spalding County Medical Society hereby instructs its delegate to present a resolution to the House of Delegates asking that the present regulations be changed to allow financial remuneration for surgical assistants.

The resolution was referred to Reference Committee No. 1.

The Chair recognized Secretary Poer, who stated that, in accordance with Section 7, Chapter I of the By-Laws, the following 170 members were entitled to Life Membership award by the Association:

BALDWIN
Y. H. Yarbrough

BEN HILL
A. Harper
S. L. McElroy

BIBB
Thomas H. Hall
W. B. Dove
J. D. Zachary

BLUE RIDGE
E. W. Watkins

BULLOCH
J. Z. Patrick

CARROLL
W. A. Aderhold
W. L. Hogue
B. C. Powell
D. S. Reese
W. P. Smith
L. E. Wilson

CHATHAM
J. F. Chisholm
W. A. Cole
W. B. Crawford
St. J. R. DeCaradeuc
Rufus E. Graham
H. Y. Righton
Jabez Jones
G. T. Olmstead
E. S. Osborne
Herman Lang
C. G. Redmond
Lloyd B. Taylor
J. W. Daniel
Charles Usher
R. V. Martin

CHEROKEE
M. Gordon Hendrix
R. M. Moore
T. J. Vansant

CLARKE
C. O. Middlebrooks
W. L. Moss
R. J. Westbrook

COLQUITT
Julius C. Stone
W. H. Whittendale

COWETA
W. H. Tanner

CRISP
J. N. Dorminy
A. J. Whelchel

DEKALB
Mary F. Sweet

ELBERT
D. V. Bailey
J. E. Johnson, Sr.
A. S. Johnson, Sr.
B. B. Mattox
A. C. Smith
D. N. Thompson
G. A. Ward

FLOYD
M. M. McCord
W. G. Banister
J. L. Garrard
W. A. Sewell

FORSYTH
W. E. Lipscomb, Sr.

FULTON
T. F. Abercrombie
Guy D. Ayer
J. G. Bachmann
James B. Baird
W. Troy Bivings
C. E. Boynton
J. N. Brawner
I. T. Catron
W. L. Champion
J. A. Combs

Virgil C. Cooke
J. H. Crawford
W. C. Dabney
John F. Denton
Thomas M. Ezzard
O. O. Fanning
Maude E. Foster
W. S. Goldsmith
E. D. Highsmith
Fred G. Hodgson
G. Pope Huguley
Claude T. Key
M. K. Jenkins
Hugh M. Lokey
Paul McDonald
J. L. Morris
R. M. Nelson
W. E. Ragan
C. H. Pinson
L. C. Rouglin
Marshall R. Sims
C. A. Rhodes
Linton Smith
Samuel A. Visanska
J. C. Weaver

GLYNN
J. W. Simmons

GORDON
George T. Banks
W. R. Barnett

GRADY
T. J. Arline
W. A. Walker
J. B. Warnell

HABERSHAM
Katherine B. Collins

HALL
B. B. Chandler

HART
W. E. McCurry

HENRY
H. C. Ellis

JACKSON
L. P. Pharr

JASPER
F. S. Belcher

LAMAR
J. A. Corry

LAURENS
J. G. Brantley
J. G. Carter
O. H. Cheek
E. B. Claxton
A. T. Coleman
C. A. Hodges
C. G. Moyer
A. D. Ware

MACON
H. C. Derrick

MERIWETHER
T. W. Jackson

MITCHELL
D. P. Belcher
C. A. Stevenson

MONROE
R. C. Goolsby, Sr.

MORGAN
J. L. Porter

MUSCOGEE
Curtis B. Carter
W. L. Cooke
G. S. Murray
J. C. Wooldridge
J. R. Youmans

OCMULGEE
J. M. Smith

POLK
P. O. Chaudron
John Good
W. H. Lucas

T. E. McBryde
G. M. White

RANDOLPH
J. T. Arnold
J. M. Kenyon

RICHMOND
W. W. Battey
G. T. Bernard
W. J. Cranston
S. J. Lewis
F. X. Mulherin
K. W. Milligan
J. R. Robertson
R. L. Rhodes
E. A. Wilcox

SOUTH GEORGIA
Frank Bird
J. F. Mixson, Sr.
T. H. Smith
Frank H. Thomas

SPALDING
R. E. L. English
D. A. Forrer
I. B. Howard
W. C. Miles

STEPHENS
J. H. Edge

SUMTER
B. T. Wise

TELFAR
A. J. Jones

THOMAS
Wm. F. Friddell
J. N. Isler

TROUP
W. R. McCall
E. R. Park
J. L. Taylor

TURNER
J. R. Baxter

UPSON
H. A. Barron

WALKER
D. S. Middleton

WARE
W. D. Mixson
John W. Oden

WASHINGTON
J. B. Dillard
O. L. Rogers

WHITFIELD
George L. Broadrick
H. L. Erwin
J. C. Rollins
Henry L. Sams

WILCOX
J. A. Bussell
V. L. Harris

WILKES
H. T. Harriss
A. W. Simpson

WORTH
Peyton E. Bell
T. C. Jefford

Upon motion duly made and seconded, the 170 members were granted Life Membership status in the Association.

The Speaker then requested that official fraternal delegates from neighboring state medical associations stand and introduce themselves.

Bringing greetings from their respective associations were Elias S. Faison, Charlotte, N. C., and Merritt R. Clements and Charles J. Collins, Tallahassee and Orlando, Fla., respectively.

Secretary Poer introduced the following guests in attendance: Julian P. Price, Member, AMA Committee on Legislation, Florence, S. C., and Samuel Day, Secretary, Florida Medical Association, Jacksonville, Fla., and Mr. H. A. Schroder, Executive Director, Blue Shield of Florida, Inc., Jacksonville, Fla.

There being no further business, upon motion duly made and seconded, the meeting of the House of Delegates was recessed until 2:00 p.m.

First Session, House of Delegates Sunday, May 10

The House of Delegates was called to order by Speaker Thomas W. Goodwin at 2:00 p.m., Gold Room, Hotel DeSoto, Savannah.

The afternoon session essentially proceeded as follows:

"Today's Challenge to Medicine" (an address)—Louis H. Bauer, President, American Medical Association, Hempstead, New York.

"The National Legislative Outlook" (an address)—Julian P. Price, Member, Committee on Legislation of the American Medical Association, Florence, S. C.

"The Blue Cross and Blue Shield Plan in Florida" (an address)—Mr. H. A. Schroder, Executive Director, Blue Shield of Florida, Inc., Jacksonville, Fla.

There being no further business, upon motion duly made and seconded, the meeting was adjourned at 3:30 p.m. until Tuesday, May 12, 3:00 p.m.

Annual Joint Memorial Service Sunday, May 10

The Annual Joint Memorial Service was held at

3:45 p.m. in the Grand Ball Room, Hotel DeSoto, Savannah, and essentially proceeded as follows:

Presiding: C. F. Holton, President, Savannah.

Invocation: The Rev. Ernest Risley, Minister, St. John's Episcopal Church, Savannah.

"It Singeth Low in Every Heart" (Hiles), Miss Edith Bennett, vocalist; Mr. Dwight J. Bruce, accompanist.

Memorial Address, The Rev. Ernest Risley.

In Memoriam: Albert J. Kelley.

IN MEMORIAM

BAIRD, Noah W., Atlanta, June 24, 1952
BARTON, John J., Dublin, July 8, 1952, age 82
BRAMBLETT, R. H., Cumming, December 16, 1952, age 66
BREWER, Asbury, Tunnel Hill, April 24, 1952, age 79
BROWN, Stewart Dixon, Royston, May 30, 1952, age 71
BROWNING, Zach Clark, Augusta, April 30, 1953, age 37
CHANDLER, William Vance, Baldwin, August 10, 1952, age 85
CHAPMAN, William Allen, Cedartown, November 30, 1952, age 87
CHEEK, Pratt, Sr., Gainesville, August 26, 1952, age 67
COBB, Tyrus Raymond, Jr., Dublin, September 9, 1952, age 42
COLSAN, Dell Cassidy, Glennwood, May 16, 1952, age 70
DEAL, Ben A., Statesboro, September 24, 1952, age 68
DOSTER, Henry William, Augusta, December 23, 1952, age 86
EAVES, B. F., Draketown, April 2, 1953, age 60
FISCHER, L. C., Atlanta, April 29, 1953, age 81
FLOURNOY, Harrison Clinton, Warwick, May 4, 1952, age 65
FORT, M. A., Bainbridge, May 9, 1953, age 81
FREDERICK, Donald B., Marshallville, June 14, 1952, age 73
FUTCH, Thomas A., Thomasville, March 20, 1953, age 44
GARNER, James Ryan, Atlanta, July 16, 1952, age 75
GILES, Jackson T., Valdosta, November 4, 1952, age 34
GREENE, Edgar Hill, Atlanta, May 30, 1952, age 63
HAIR, William B., Summerville, September 5, 1952, age 60
HATTAWAY, John Calvin, Jr., Edison, November 29, 1952, age 52
HAYS, W. C., Colquitt, September 14, 1952, age 72
HOLLOMAN, Alfred Leon, Savannah, October 20, 1952, age 38
HUMPHREY, Thomas S., Springfield, August 20, 1952, age 77
HUMPHREYS, Alexander S., Brooks County, September 4, 1952, age 86
HUNT, G. C. D., Cordele, November 27, 1952, age 82
HUTCHINSON, Lee Roy, Adel, June 1, 1952, age 61
IRVIN, I. W., Albany, April 26, 1953, age 61
JONES, Henry, Coolidge, April 30, 1952, age 82
LANIER, John Edward, Colquitt County, January 25, 1953, age 80
LANIER, John Roy, Swainsboro, July 7, 1952, age 51
LEE, Lawrence, Sr., Savannah, January 11, 1953, age 72
LINDLEY, F. P., Powder Springs, January 1, 1953, age 62
MANGET, James D., Atlanta, August 16, 1952, age 70
MATTHEWS, O. H., Atlanta, November 23, 1952, age 74
McGEE, Harry H., Savannah, age 51
McGOWAN, Hugh Strong, Cartersville, December 19, 1952, age 71
MILLER, Harold Applegate, Augusta, September 22, 1952, age 78
MOBLEY, H. A., Vienna, January 2, 1953, age 86
OWENSBY, Newdigate Moreland, Atlanta, August 10, 1952, age 69
PETTIT, James K., Atlanta, May 22, 1952, age 63
RIDLEY, Frank M., Jr., LaGrange, January 29, 1953, age 69
SAGGUS, John Gordon, Harlem, November 24, 1952, age 64

SHANKS, Edgar DeWitt, Atlanta, February 12, 1953, age 63
SMITH, D. D., Swainsboro, March 16, 1953, age 68
SMITH, Racy Hawkins, Lincolnton, May 4, 1952
SPRUELL, T. M., Carroll County, July 25, 1952, age 84
SUMNER, Gordon S., Worth County, March 13, 1953, age 68
TYRE, J. Lawson, Screven County, October 4, 1952, age 66
VEALE, E. O., Arnoldsville, March 10, 1953, age 77
VINTON, Luther Mansfield, Atlanta, July 2, 1952, age 63
VOGT, Elkin, Lithonia, May 5, 1952, age 49
WILKINSON, William Lee, Bainbridge, May 24, 1952, age 64
WOCD, Kenneth, Leslie, March 20, 1953, age 63

"The Lord's Prayer" (Malotte), Miss Bennett and Mr. Bruce.

Benediction.

Open Public Meeting Sunday, May 10

Under sponsorship of the Woman's Auxiliary to the Medical Association of Georgia, an open public meeting was held at 4:30 p.m. in the Grand Ball Room, Hotel DeSoto, Savannah. The meeting essentially proceeded as follows:

Presiding: Mrs. Ralph Fowler, Auxiliary President, Marietta.

Introduction: Mr. Kirk Sutlive, President Savannah Chamber of Commerce, Savannah.

"Are We Educating or Indoctrinating Our Children?", Mr. Arthur L. Conrad, President, The Heritage Foundation, Inc., Chicago.

The meeting was concluded at approximately 5:30 p.m.

Monday Morning, May 11

Opening Session

The session was called to order by President C. F. Holton at 8:30 a.m. in the Grand Ball Room, Hotel DeSoto, Savannah.

The Rev. Joseph L. Griffen, Pastor, St. Paul's Lutheran 46—MED JOURNAL Church, Savannah, rendered the invocation.

Initial welcoming addresses were given by the Hon. Glin F. Fulmer, Mayor of Savannah, and President Howard J. Morrison of the Georgia Medical Society, Savannah.

Louis H. Bauer, President, American Medical Association, Hempstead, N. Y., was introduced by President Holton and briefly addressed the audience.

The opening session was concluded at approximately 9:20 a.m.

The morning program ensued in essentially the following order:

9:00 PANEL DISCUSSION:

Grand Ballroom, DeSoto Hotel.

"The Program of Vocational Rehabilitation in Georgia", Carl C. Aven, Atlanta, Moderator. Discussors: Mr. A. P. Jarrell, Assistant Director, Division of Vocational Rehabilitation, Atlanta; Thomas P. Goodwyn, Atlanta; Julian K. Quattlebaum, Savannah; Lester Harbin, Rome; Milford B. Hatcher, Macon; Braswell E. Collins, Waycross.

9:00 CLINICAL SESSION:

Gold Room, Hotel DeSoto.

Presiding: H. L. Cheves, Union Point.

SYMPOSIUM:

"Neuropsychiatry in General Practice."

"Present Facilities and Future Needs in Psychiatry in Georgia", Raymond S. Crispell, Atlanta. Discussors: T. G. Peacock, Milledgeville; J. R. S. Mays, Macon.

"Drug Therapy in Senile and Arteriosclerotic Psychoses", H. Dawson Allen, Jr., Milledgeville. Discussors: Lawrence F. Woolley, Atlanta; Harry R. Lipton, Atlanta.

"A Study of Squints at Gracewood, Georgia Training School for Mental Defectives", Henry R. Perkins, Augusta. Discussors: J. Victor Roule, Augusta; Norman B. Pursley, Gracewood; F. Phinizy Calhoun, Jr., Atlanta.

"Some Methods That Have Proved Useful in the Beginning of Psychotherapy With Neurotic Patients", John Warkentin, Atlanta. Discussors: Rives C. Chalmers, Atlanta; Leonard T. Maholick, Columbus.

11:00 CLINICAL SESSION:

Grand Ballroom, Hotel DeSoto.

Presiding: H. Dawson Allen, Milledgeville.

"Care of the Premature Infant", Heyworth N. Sanford, Chicago.

"Gastrointestinal Bleeding", Robert D. Moreton, Ft. Worth, Texas.

"Acute Cholecystitis", Alton Ochsner, New Orleans, La.

At the conclusion of the scientific talks, President Holton presented his annual address, outlining the remarkable medical progress made in Georgia during the initial half of the Twentieth Century, and for which the Medical Association of Georgia could assume much credit.

J. C. Metts, Savannah, with pertinent remarks, presented the President's Key to President Holton.

Chairman Mark S. Dougherty, Jr., of the Committee on Awards read the names of and made presentation of the Fifty-Year Certificates and lapel buttons to the following members who, in 1953, had practiced medicine fifty years: Thomas F. Abercrombie, Atlanta; David A. Bagley, Austell; John F. Denton, Atlanta; W. P. Ezzard, Lawrenceville; Mannie A. Fort, Bainbridge; John Elmo Garner, Thomaston; Thomas H. Hall, Macon; Horace C. McCrackin, Baxley; Richard M. Nelson, Atlanta; William H. Tanner, Newnan; James R. Wallis, Lovejoy; Lloyd E. Wilson, Bowden.

Chairman Dougherty, with pertinent remarks, then awarded the Ware County Cup to Charles Daniel Bowdoin, Atlanta, for his outstanding service in and contribution to the field of public health.

Co-Chairman Hoke Wammock of the Committee on Awards, in behalf of the Medical Association of Georgia, presented Certificates of Appreciation to Spencer A. Kirkland, Atlanta, for his long and valuable service as Legislative Committee Chairman; to G. Lombard Kelly, Augusta, for outstanding service in the field of medical education; to Charley K. Wall, Thomasville, for untiring service as Second District Councilor; and to Marion C. Pruitt, Atlanta, for faithful devotion to duties as Fifth District Councilor.

Chairman Dougherty announced that the Awards Committee had selected three winning scientific exhibits, in the following order: "Malignant Lymphoma of the Stomach," I. R. Berger, Atlanta; "Bleeding from the Gastrointestinal Tract," Charles W. Hock, Augusta; and "Plastic Surgery of the Nose," John R. Lewis, Jr., Atlanta.

President Holton then declared the meeting open for nomination of officers from the floor.

Duly nominated and seconded were Peter B. Wright, Augusta, and Stephen T. Brown, Atlanta, for President-Elect; James C. Metts, Savannah, for First Vice-President; Milford B. Hatcher, Macon, for Second Vice-President; Charles Richardson, Sr., Macon, and J. W. Chambers, LaGrange, for AMA Delegate; and C. L. Ayers, Toccoa, for AMA Alternate Delegate.

Official nominations for Councilor and Vice-Councilor from the Fifth, Sixth, Seventh and Eighth District Medical Societies were announced to be Mark S. Dougherty, Jr., Atlanta, Councilor, and J. G. McDaniel, Atlanta, Vice-Councilor, Fifth District; H. Dawson Allen, Jr., Milledgeville, Councilor, and H. G. Weaver, Macon, Vice-Councilor, Sixth District; D. Lloyd Wood, Dalton, Councilor, and Ralph W. Fowler, Marietta, Vice-Councilor, Seventh District; and Neal F. Yeomans, Waycross, Councilor, and James M. Hicks, Brunswick, Vice-Councilor, Eighth District.

President Holton then announced that the Committee on Tellers was comprised of C. L. Ayers, Chairman, Toccoa; J. C. Patterson, Cuthbert, and W. F. Reavis, Waycross. He further announced the location of the official ballot box and the voting hours and regulations established by the Committee on Tellers.

The meeting adjourned at approximately 1:05 p.m.

Monday Afternoon, May 11

The afternoon scientific program ensued in essentially the following order:

2:00 GENERAL SURGERY:

Sapphire Room, Hotel DeSoto.

Presiding: Thomas Harrold, Macon, Chairman.

"The Early Diagnosis and Treatment of Cancer of the Stomach", Alton Ochsner, New Orleans.

"Congenital Reduplication of the Stomach", John T. Akin, Atlanta. Discussors: J. H. Sherman, Augusta; Lon W. Grove, Atlanta.

"Strictures of the Common Bile Duct", James L. Caldwell, Macon. Discussors: Lester Harbin, Rome; Thomas W. Goodwin, Augusta.

"The Treatment of Gastroduodenal Hemorrhage with Coagulating Agents", John M. McClure, Jr., Atlanta. Discussors: A. G. Little, Jr., Valdosta; David F. James, Atlanta.

"Improved Technique in Hemorrhoidectomies with Discussion of Postoperative Discomfort", Richard A. Krause, Augusta. Discussors: James C. Thoroughman, Augusta; Edgar Boling, Atlanta.

2:00 PEDIATRICS:

Colonial Room.

Presiding: John A. Simpson, Athens.

"Some Problems in the Care of the New-born", Heyworth N. Sanford, Chicago.

"Adjustment Problems With Children", Thomas E. Bailey, Augusta. Discussors: Howard J. Morrison, Savannah.

"The Pediatrician as Family Advisor", William H. Kiser, Jr., Atlanta.

"Surgical Correction of Achalasia of the

Esophagus in Infants", Richard King, Atlanta. Discussors: M. Hines Roberts, Atlanta; C. Hall Farmer, Macon.

2:00 RADIOLOGY:

Chatham Room.

Presiding: Robert M. Tankesley, Atlanta.

"Roentgenologic Examination of the Colon", Robert D. Moreton, Fort Worth, Texas.

Roentgenogram Demonstration.

3:30 Symposium on Radiological Procedures in General Practice.

"Radiologic Investigation of Obstructing Lesions of the Colon", Ted F. Leigh, J. W. Rogers, Jr., Brit B. Gay, Jr., and Jose Bonmati, all of Emory University. Discussors: J. D. Martin, Jr., Emory University; Stephen W. Brown, Augusta.

"Roentgenographic Diagnosis of Gall Bladder Disease", J. J. Collins, Thomasville. Discussors: Palmer Holmes, Augusta; Robert C. Pendergrass, Americus.

"Roentgen Treatment of Certain Benign Conditions", Bert H. Malone, Brunswick. Discussors: Frank G. Eldridge, Valdosta; Neal F. Yeomans, Waycross.

2:00 UROLOGY:

Oglethorpe Club, 450 Bull St.

Presiding: Reese C. Coleman, Atlanta.

Pyelographic Clinic.

Tuesday Morning, May 12

The morning scientific program proceeded in essentially the following order:

9:00 SYMPOSIUM ON GASTROENTEROLOGY:

Grand Ballroom, Hotel DeSoto.

Moderator: E. Van Buren, Atlanta.

"Reasons for Failure in the Therapy of Peptic Ulcer Patients", Charles W. Hock, Augusta.

"Further Observations on Use of Vagotomy for Duodenal Ulcer", Charles H. Richardson, Jr., Macon.

"The Diagnosis of Carcinoma of the Pancreas", Henry H. Tift, Macon. Discussors: J. Benham Stewart, Macon; T. R. Freeman, Savannah. W. Derrell Hazlehurst, Macon; John S. Atwater, Atlanta; E. L. Bosworth, Rome; George Walker, Griffin.

"The Relationship of Nutritional and Soil Deficiencies", W. W. Turner, Nashville. Discussors: T. F. Sellers, Atlanta; Mary Spiers, Ph.D., Experiment.

SYMPOSIUM ON ORTHOPEDICS AND TRAUMA:

Gold Room, Hotel DeSoto.

Moderator: Sage Harper, Douglas.

"Irreducible Supracondylar Fractures in Chil-

dren: Treatment by Intramedullary Transfixion", Charles M. Henry, Clarkesville. Discussors: C. G. Henry, Augusta; R. P. Kelly, Jr., Emory University.

"The Ruptured Intervertebral Disk Syndrome", Louis A. Hazouri, Columbus.

Discussors: Edgar F. Fincher, Jr., Emory University; L. O. J. Manganiello, Augusta.

"Osteitis Condensans Ilii", David Robinson and W. U. Clary, Savannah. Discussors: Peter B. Wright, Augusta; Ernest G. Edwards, Savannah.

10:00 SYMPOSIUM ON VASCULAR SURGERY:

Moderator: W. Bruce Schaefer, Toccoa.

Surgery in Some Vascular Emergency Conditions", Robert B. Gottschalk, Savannah.

"Successful Anastomosis of Common and Internal Carotid Arteries Following Resection of Defective Portion", P. C. Shea, Jr., Atlanta. Discussors: David Henry Poer, Atlanta; William G. Whitaker, Atlanta; Julian K. Quattlebaum, Savannah; Daniel C. Elkin, Emory University.

11:00 GENERAL SESSION:

Grand Ballroom, Hotel DeSoto.

Presiding: D. Lloyd Wood, Dalton.

"Dysfunction of the Colon"—Lemuel C. McGee, Wilmington, Del.

"Our Aging Population", J. P. Sanders, Shreveport, La.

"General Aspects of Leptospiral Infection", Walter H. Sheldon, Emory University.

ABNER W. CALHOUN LECTURE:

C. F. Holton, President, Medical Association of Georgia, Chairman, presiding.

"Some Recent Advances in Hematology", Cyrus C. Sturgis, Ann Arbor, Michigan.

Tuesday Afternoon, May 12

The afternoon scientific program ensued in essentially the following order:

2:00 PATHOLOGY:

Habersham Room.

Presiding: Darrell Ayer, Atlanta.

"Leptospiral Infection", Walter H. Sheldon, Emory University.

2:00 INDUSTRIAL SURGERY AND MEDICINE:

Sapphire Room.

(Sponsored by Georgia Industrial Surgeons Association)

Presiding: Joseph C. Read, Atlanta.

"Operational Responsibilities of a Medical Department in Industry", Lemuel C. McGee, Wilmington, Del.

"Treatment of Industrial Eye Injuries", Cyrus W. Stoner, Atlanta. Discussor: Braswell E. Collins, Waycross.

"Recent Progress in the Management of Patients With Intervertebral Disk Lesions", Exum Walker, Atlanta. Discussors: C. F. Holton, Savannah; Robert F. Mabon, Atlanta.

SYMPOSIUM ON BURNS:

Moderator: Ben R. Thebaut, Atlanta.

"The Mass Treatment of Burns in Atomic Warfare"—Joseph R. Shaeffer, Col., MC, Washington, D. C.

"The Early Treatment of Burns", George S. Tootle, Atlanta.

"The Late Treatment of the Severely Burned Patient", S. A. Roddenberry, Columbus. Discussors: Milford B. Hatcher, Macon; Kirk Shepard, Thomasville; Edward S. Marks, Marietta; John R. Lewis, Atlanta.

Second Session, House of Delegates Tuesday, May 12

The House of Delegates was called to order by Speaker Thomas W. Goodwin at 3:00 p.m. in the Georgia Medical Society auditorium, 612 Drayton Street, Savannah.

By motion (Eustace A. Allen-John W. Turner) reading of minutes, to be published in the June issue of *The Journal of the Medical Association of Georgia*, was dispensed with.

Chairman John Elliott of the Credentials Committee, upon motion duly made and seconded, accepted official delegate's attendance slips in lieu of a roll call and reported a quorum present.

The following official delegates were in attendance: BIBB—J. B. Kay, Sam Patton, T. L. Ross, Jr., and J. B. Stewart; GEORGIA MEDICAL SOCIETY—John L. Elliott and Ruskin King; CHEROKEE-PICKENS—C. J. Roper; CLAYTON-FAYETTE—T. J. Busey; CLARKE—M. A. Hubert and John A. Simpson; CRISP—P. L. Williams; COWETA—J. H. Arnold; DECATUR-SEMINOLE—Edwin M. Griffin; DEKALB—W. K. Kerr; DOUGHERTY—Glenn E. Seymour; FLOYD—C. J. Wyatt, Jr.; FORSYTH—Marcus Mashburn; FULTON—John S. Atwater, Donald S. Bickers, Tully T. Blalock, Edgar Boling, E. N. Burson, Stephen T. Brown, Shelley C. Davis, Harry Lange, A. H. Letton, M. C. Pruitt, J. L. Rankin, C. Purcell Roberts, C. Richard King, John R. Lewis, Jr., J. Harry Rogers, Lester Rumble, Jr., B. L. Shackelford, Duncan Shepard, Henry E. Steadman, John W. Turner; GORDON—L. R. Lang; GWINNETT—D. C. Kelley; HABERSHAM—J. J. Arrendale; JASPER—E. M. Lancaster; JENKINS—A. P. Mulkey; McDUFFIE—A. G. LeRoy; MERIWETHER-HARRIS—W. P. Kirkland; MONROE—George H. Alexander; MUSCOGEE—A. B. Conger, Jr., Frank B. Schley, S. A. Roddenberry and L. J. Roberts; NEWTON—Clarence B. Palmer and Robert M. Paty, Jr.; POLK—W. H. Lucas; RABUN—George H. Boyd, Jr.; RANDOLPH-TERRELL—Earl A. Mayo; RICHMOND—Thomas Goodwin, R. C. McGahee and D. R. Thomas, Jr.; SOUTH GEORGIA MEDICAL SOCIETY—A. G. Little and Fred Clements; SPALDING—Virgil B. Williams; SUMTER—B. M. Durham; THOMAS—George R. Dillinger; TROUP—Charles T. Cowart; UPSON—T. A. Sappington; WALKER-CATOOSA-DADE—Fred H. Simonton; WARE—W. L. Pomeroy and Leo Smith; WARREN—H. B. Cason; WASHINGTON—B. L. Helton; WHITFIELD—Paul Bradley; WORTH—H. G. Davis, Jr.

Also in attendance were Past Presidents C. H. Richardson,

Clarence L. Ayers, Allen H. Bunce, Ralph H. Chaney, Enoch Callaway and W. F. Reavis.

Officers present were President C. F. Holton, President-Elect W. P. Harbin, Jr., First Vice-President Rudolph Bell, Secretary-Treasurer D. H. Poer.

AMA Delegates Eustace A. Allen and C. H. Richardson were present.

The following Councilors were in attendance: George R. Dillinger, W. G. Elliott, J. W. Chambers, Marion C. Pruitt, H. Dawson Allen, D. L. Wood, Sage Harper, W. Bruce Schaefer and H. L. Cheves.

Vice Councilors present were Clarence B. Palmer and John W. Turner.

Also present were Ralph W. Fowler, Spencer A. Kirkland, William H. Gallaway, J. D. McElroy, Hoke Wammock.

There being no unfinished nor new business for House consideration, Speaker Goodwin called for the Reference Committee Reports.

REPORT OF REFERENCE COMMITTEE NO. 1

Chairman Enoch Callaway presented the following report:

1. *Report of the President*—Your Committee would like to congratulate the President on the attainments of the Association in the past year. The comments and recommendations made in the report show evidence of interested study of the needs of this Association and it is recommended that these suggestions be carefully considered by the proper committees or agencies and that the Report be adopted for information.

2. *First District Councilor Report*—The Committee wishes to commend Dr. Lee Howard for the reactivation of the First District Society which had been dormant for sometime. We feel that with the recovery of Dr. Charles Brown, he will be available for help. This Councilor has done a good job and we recommend the adoption of this report for information.

3. *Fifth District Councilor Report*—Dr. Marion C. Pruitt, Councilor of the Fifth District, has reported a good increase in membership, and we recommend adoption of this report for information.

4. *Ninth District Councilor Report*—Dr. W. Bruce Schaefer, Councilor of the Ninth District, presented a very concise summarized statement of conditions and membership in the Ninth District which shows a nice increase in membership, and we recommend adoption of this report for information.

5. *Committee on Maternal Welfare*—The report of this Committee shows evidence of much intelligently directed work and the Committee is to be commended. It is recommended that every doctor read this report. We recommend its adoption for information.

6. *Committee on Professional Conduct*—It is the recommendation of this Committee that this report be adopted for information.

7. *Committee on History and Vital Statistics*—The report of this Committee was read and Reference Committee No. 1 would recommend that the doctors throughout the state give this Committee their full cooperation. We recommend adoption of this report for information.

8. *Committee on Insurance*—This Committee and its Chairman are to be congratulated upon the good work they have done in inaugurating the Georgia Plan. The Committee believes that this Plan is an excellent foundation upon which to build in the future, and this Committee would like to specifically recommend that the Committee on Insurance investigate the feasibility of establishing the contract between members of the Medical Association of Georgia and the insurers so that family income and not individual income would be the criterion upon which the fees charged will be based. We recommend adoption of this report for information.

9. *In re Resolution presented by Cobb County Medical Society* to allow doctors to charge higher or extra fees where there is additional insurance coverage: It is the opinion of the Committee that such practices would confuse and disrupt the entire system of prepayment care. Therefore, we recommend disapproval of this resolution.

10. *In re Resolution from Spalding County Medical Society* asking that fees for services of surgical assistants be added to Georgia Plan: It is the opinion of this Committee that such a plan would result only in increasing surgical

fees in a category in which we believe the fees to be adequate. Therefore, we recommend disapproval of this Resolution.

11. *Committee on Blood Banks*—This Committee has done work and has laid a solid ground work for achieving much good. The potentialities for the benefit to be achieved by this Committee are unlimited. We recommend adoption of this report for information.

12. *Committee on Chronic Illness*—The report of this Committee presents a resume of what is and can be done for the chronically ill or disabled in Georgia. We recommend adoption of this report for information.

13. *Treasurer's Report*—The Committee recommends the adoption of the Treasurer's Report.

14. *Council Report*—The Committee recommends adoption of this report. However, the Committee would recommend that in the future, funds of the Association should not be used for the entertainment of members.

15. *Committee on Medical Defense*—The Reference Committee wishes to call attention to and commend the work of this Committee. It would like also to commend and thank the attorney for his interest and excellent work in this Committee's and the Association's behalf. We would like also to call attention to the fact that most claims have arisen from careless or unthoughtful remarks made to a patient by a doctor, and the Committee recommends that doctors refrain from criticism of another doctor unless he is acquainted with the doctor's as well as the patient's view of any misunderstanding. The Reference Committee recommends further that in case a doctor is notified of a claim's being filed or considered against him that he not reply, but communicate directly with the attorney or the Chairman of the Committee on Medical Defense.

16. *Crawford W. Long Memorial Fund*—It is recommended by Reference Committee No. 1 that if funds are available \$1,000 be contributed by Council to the Crawford W. Long Memorial Fund and that this fund be brought to the attention of the members of the Medical Association of Georgia for their endorsement and to give individual members an opportunity to make personal donations.

17. *Better Health Council*—Your Committee has read the Report of the Better Health Council by Mrs. Shelley Davis and wishes to commend Mrs. Davis for the work she has done. The Committee is fully cognizant of the good public relations value of this work and is in full sympathy with it. The Reference Committee recommends adoption of this report.

18. *Budget*—This Committee recommends the increase in annual dues of the Medical Association of Georgia from the present \$15.00 to \$25.00 as recommended by the Budget Committee; as it is apparent that the present high level of service cannot be rendered to the members from the present income of the Association. To facilitate better bookkeeping, your Reference Committee recommends that the fiscal year be changed from April 1 through March 31 to January 1 through December 31. The Budget Committee recommends that Council and the House of Delegates give serious thought to the meeting place for the annual meeting of this Association for the immediate future since income from exhibitors for 1953-54, you will note, dropped from \$9,000 the present fiscal year to \$5,480 for the next fiscal year. The Reference Committee feels that this matter should be given immediate and careful consideration by the House of Delegates. Your Reference Committee No. 1 recommends adoption of this budget and at the same time recommends that every effort be made to practice economies where possible.

ENOCH CALLAWAY, Chairman
JOHN W. TURNER
MARCUS MASHBURN
C. J. WYATT, JR.

Chairman Callaway moved for adoption of the reference committee report (Section 1-7) dealing with reports of the President; First, Fifth and Ninth District Councilors; and Committees on Maternal Welfare, Professional Conduct and History and Vital Statistics. The motion was duly seconded and carried.

The reference committee report (Section 8) dealing with the Insurance Committee report was adopted on motion of Chairman Callaway, seconded by John Elliott, which carried.

On motion of Chairman Callaway, seconded by Marion C. Pruitt, and carried, the reference committee report (Sections 9-10) disapproving resolutions of Cobb and Spalding County Medical Societies was adopted.

Chairman Callaway moved for adoption of the reference committee report (Sections 11-12) pertaining to reports of the Committees on Blood Banks and Chronic Illness. The motion was duly seconded and carried.

The reference committee report (Section 13) about the Treasurer's report was adopted on motion of Chairman Callaway, seconded by John Elliott, which carried.

On motion of Chairman Callaway, seconded by D. Lloyd Wood, and carried, the reference committee report (Section 14) dealing with the report of the Council Chairman was adopted.

It was moved by Chairman Callaway, seconded by W. L. Pomeroy, and carried, that the House adopt the report of the reference committee (Section 15) pertaining to the report of the Medical Defense Committee.

The reference committee report (Section 16) dealing with the Crawford W. Long Memorial Fund Committee report was adopted on the motion of Chairman Callaway, seconded by David R. Thomas, Jr., and carried.

On motion of Chairman Callaway, seconded by Thomas L. Ross, Jr., and carried the reference committee report (Section 17) about the Better Health Council of Georgia was adopted.

Relative to reference committee report (Section 18) dealing with Audit and Appropriations Committee budgetary recommendations:

On motion of Chairman Callaway, seconded by J. B. Kay, and carried, the recommendation that annual dues be raised to \$25.00, effective January 1, 1954, was approved, following discussion by Marcus Mashburn, John W. Turner, C. F. Holton and J. W. Chambers.

On motion of Chairman Callaway, seconded by A. H. Letton, and carried, the recommendation that the Association fiscal year be changed from April 1 through March 31 to January 1 through December 31 was approved.

On motion of President Holton, seconded by J. B. Kay, and carried, the site of Macon for the 1954 Annual Session was approved, subject to necessary formalities, after discussion by Thomas L. Ross, Jr.

It was moved by Chairman Callaway, seconded by J. B. Stewart, and carried, that the budget, as presented by the Council Audit and Appropriations Committee, be adopted.

On motion of Chairman Callaway, seconded by J. B. Kay, and carried, the report of Reference Committee No. 1 was adopted as a whole.

REPORT OF REFERENCE COMMITTEE NO. 2

Chairman Ralph H. Chaney presented the following report:

1. The Report of the Secretary is accepted and his recommendations are approved, deleting the line "or Trustees" in paragraph 2 of the summary.

2. Recommended acceptance of the reports from the 2nd, 6th and 10th Districts and recommend that Council take the necessary steps to consolidate the smaller county units into larger societies.

3. The Report of the Committee on Rural Health is accepted.

4. The Report of the Committee on Public Health is accepted and the Committee endorses the four requests of the State Health Department contained therein.

5. The Committee commends Mrs. Ralph W. Fowler for the magnificent work she has done in carrying on her job. This Committee recommends the continuance of previous financial support and further recommends that the President of the Auxiliary be given a stipend to cover stenographic and clerical outlay. This committee recommends that the Constitution and By-Laws be left in status quo allowing the President to appoint the Advisory Committee to the Woman's Auxiliary.

6. This Committee recommends the adoption of the resolution presented by Dr. C. J. Wyatt, commending Dr. Poer for his accomplishments.

7. This Committee transmits for discussion on the floor the Resolution from Troup County.

8. This Committee recommends that information submitted by Dr. Fred Simonton from the American Academy of General Practice be accepted as information, inasmuch as these resolutions did not originate in any constituent of the Medical Association of Georgia, therefore leaving it without power to act.

9. The Medical Advisory Committee to Selective Service Report covers a very definite problem in a precise manner which is summed up in the resolution introduced which we recommend passage of.

RALPH H. CHANEY, Chairman,
Augusta
DUNCAN SHEPARD, Atlanta
RALPH W. FOWLER, Marietta

Chairman Chaney moved that the reference committee report (Section 7) dealing with the Troup County Medical Society resolution immediately be referred to the House floor for discussion. The motion was seconded by Thomas L. Ross, Jr., and carried.

Prolonged discussion ensued by Charles T. Cowart, W. F. Reavis, C. L. Ayers, Edgar Boling, Lester Rumble, Marion C. Pruitt, David R. Thomas, Jr. and Enoch Callaway.

On motion of W. F. Reavis, seconded by W. L. Pomeroy and carried, the scheduling of Sunday meetings of the House of Delegates during future Annual Sessions would be left to the discretion of the Council which perforce must consider the recommendation of the House that no Sunday meetings be scheduled prior to 2:00 p.m.

Chairman Chaney moved that the report of Reference Committee No. 2 be adopted as a whole, and the motion was seconded by Fred H. Simonton, and carried.

REPORT OF REFERENCE COMMITTEE NO. 3

Chairman Fred H. Simonton presented the following report:

1. The Reference Committee considered the Executive Secretary, Mr. Sid Wrightsman's Report as printed. The Committee approved and commended the Executive Secretary for his excellent work.

2. The Reference Committee approved and commended Dr. W. G. Elliott of the 3rd District, and Dr. Lloyd Wood of the 7th District for their splendid report and work as Councilors.

3. The Committee reviewed Dr. Spencer A. Kirkland's report of the Committee on Legislation, and wish to commend Dr. Kirkland and Committee for their splendid work. Our committee considered the resolution of this Committee and after careful consideration recommended it not be approved.

4. The Report of the Committee on Public Relations given by Dr. Brown, Chairman, was thoroughly studied, and we wish to commend this Committee for its work during the past year. The Committee's recommendation that it put a full time Public Relations Director is disapproved, as we feel this can be handled with our present office force.

5. Report of the Committee on Constitution and By-Laws. With reference to the proposed amendments to the Constitution and By-Laws, we do not recommend any changes in the proposed Constitution, Article VI, Section 2, and Article VIII. We do recommend the following changes to the Constitution, Article IX, Section 1:

OFFICERS

(Section I now reads)

The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor from each of the Councilor District Societies as provided in the By-Laws.

(Proposed amendment to Section I)

The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor and a Vice-Councilor from each of the Councilor District Societies, as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

(Recommended amendment to Section I)

The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor and a Vice-Councilor from each of the Councilor Districts. All elections shall be held as prescribed in the By-Laws.

In Chapter III of the By-Laws we approve amendment to Section 2 by deleting March 1st and adding December 31st of the preceding.

Under Chapter III, we disapprove amending Section 4, in view of the fact that the position of the speaker of the House of Delegates is not provided for as a state officer under the Constitution and By-Laws, and since most of the counties at this time elect delegates annually, there is no assurance that the speaker elected would be a member of the House of Delegates at the next Annual Session. We further recommend that changes in the Constitution be considered to provide for the election of the speaker and speaker pro tem of the House of Delegates as officers.

We approve the change in Chapter III, Section 5 as recommended. Since Section 4 was not approved, Section 6 and Section 7 could not be approved.

We recommend in Chapter VI, Section 4, that, following the word "Secretary-Treasurer," the words "or his representative" be inserted.

We approve the change as recommended in Chapter VIII, Section I. An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

This Committee has given due consideration to the recommendations of appointment of special committees and it is our opinion that standing committees on hospitals and veterans affairs be provided for in the By-Laws. We feel, however, that the officers and the Constitution and By-Laws Committee of the Medical Association of Georgia should give this their consideration during the next year.

We recommend no change in Chapter IX, Section 12.

6. We approve the Honorary Advisory Board resolution.

7. The Committee has studied the report of the Medical Preparedness Committee and we commend them for their work, and we approve of all their recommendations, and we feel that every Georgian should render their full cooperation.

8. The Committee recommends and approved Dr. Patterson's resolution on Fluoridation of Water.

I wish to thank Drs. D. R. Thomas, Wm. F. Reavis and A. P. Mulkey for their fine cooperation in formulating this report.

FRED H. SIMONTON, Chairman
DAVID R. THOMAS, JR.
WM. F. REAVIS
A. P. MULKEY

Chairman Simonton moved for adoption of the reference committee report (Sections 1-2) dealing with reports of the Executive Secretary and Councilors of Third and Seventh Districts. The motion was seconded by John W. Turner, and carried.

The report of the Reference committee (Section 3) pertaining to the report of the Committee on Legislation, with specific reference to the Committee's resolution, was discussed by Chairman Simonton, Spencer A. Kirkland, J. Harry Rogers, W. F. Reavis, Ruskin King, Charles Richardson, Sr., and Marcus Mashburn.

Secretary Poer suggested that the resolution be re-worded to read as follows:

"BE IT RESOLVED: That our Legislature and our Governor be requested fully to cooperate to the extent that any and all laws pertaining to future medical legislation relative to Georgia Medicine be referred to the Committee on Legislation of the Medical Association of Georgia, a procedure and courtesy which the Association will profoundly appreciate."

It was moved by Enoch Callaway, seconded by Spencer A. Kirkland, and carried that the resolution as re-written, be approved.

Chairman Simonton moved for adoption of the reference committee report (Section 4) dealing with the report of the Public Relations Committee. The motion was seconded by W. F. Reavis, and carried.

On motion of Chairman Simonton, seconded by David R. Thomas, Jr., and carried, the report of the reference committee (Section 5, first paragraph) was adopted which dealt with the report of the Committee on Constitution and By-Laws concerning amendments to the Constitution as proposed at the 1952 Annual Session.

Chairman Simonton moved for adoption of the reference committee report (Section 5, paragraphs 2-8) pertaining to amendments to the By-Laws as presented in the report of the Committee on Constitution and By-Laws. The motion was seconded by Thomas L. Ross, Jr., and carried.

It was moved by Chairman Simonton, seconded by Eustace A. Allen, and carried that Chapter VI, Section 4(c) of the By-Laws be amended to provide for the revised Association fiscal year from January 1 through December 31.

Chairman Simonton moved for adoption of the reference committee report (Section 6) dealing with the Honorary Advisory Board resolution included in the report of the Constitution and By-Laws Committee. The motion was seconded by David R. Thomas, Jr., and carried.

On motion of Chairman Simonton, seconded by J. Harry Rogers, and carried, the reference committee report (Section 7) pertaining to the report of the Medical Preparedness Committee was adopted.

It was moved by Chairman Simonton, seconded by Tully T. Blalock, and carried, that the reference committee report (Section 8) pertaining to the resolution on fluoridation of water be adopted.

On motion of Chairman Simonton, seconded by John Elliott, and carried, the report of Reference Committee No. 3 was adopted as a whole.

REPORT OF REFERENCE COMMITTEE NO. 4

Chairman A. G. Little presented the following report:

1a. Report of the Editor of the Journal of the Medical Association of Georgia. We recommend that the report be approved as printed.

1b. Report of the Managing Editor of the Journal of the Medical Association of Georgia. We recommend that the report be approved as printed.

2. 4th District Councilor Report. We recommend that the report be approved as printed.

3. 8th District Councilor Report. We recommend that the report be approved as printed.

4. Committee on Medical Education and Hospitals. We recommend that the report be approved as printed.

5. Committee on Industrial Health. It is recommended that the report of the Committee on Industrial Health be filed for information, and that no action be taken until further study may be made by the incoming Committee.

6. Committee on Cancer. We recommend that the Report be approved as printed.

7. Committee on American Medical Education Foundation. We recommend that the report be approved as printed.

8. Committee on Committee Reorganization. We recommend that the report be approved as printed.

9. Committee on Veterans Affairs. We recommend that the report be approved as printed, and that the supplementary recommendations be filed for future guidance, as we do not feel that any action by the House of Delegates is necessary.

10. American Medical Association Delegate's Report. We recommend that the report be approved as presented.

11. Resolution of Dr. A. H. Letton from Fulton County Medical Society. We recommend the approval of this Resolution.

12. Resolution of Dr. Lester Rumble from the Fulton County Medical Society. We recommend that this Resolution be approved with the exception of recommendations two and three.

A. G. LITTLE, Chairman
CULLEN McCARVER, JR.

Chairman Little moved for adoption of the reference committee report (Section 1a) dealing with the report of the Editor. The motion was seconded by John Elliott, and carried.

The reference committee report (Section 1b) dealing with the report of the Managing Editor was adopted on motion of Chairman Little, seconded by Eustace A. Allen, and carried.

On motion of Chairman Little, seconded by Enoch Callaway, and carried, the reference committee report (Sections 2,3) pertaining to the reports of the Fourth and Eighth District Councilors was adopted.

Chairman Little moved for the adoption of the reference committee report (Section 4) concerning the report of the

Committee on Medical Education and Hospitals. The motion was seconded by Fred H. Simonton, and carried.

The reference committee report (Section 5) dealing with the Committee on Industrial Health was adopted on motion of Chairman Little, seconded by W. F. Reavis, and carried.

On motion of Chairman Little, seconded by Ruskin King, and carried, the reference committee report (Section 6) concerning the Committee on Cancer was adopted.

Chairman Little moved for adoption of the reference committee report (Section 7) dealing with the Committee on American Medical Education Foundation. The motion was seconded by John Elliott, and carried.

The reference committee report (Section 8) on the Committee on Committee Reorganization was adopted on motion of Chairman Little, seconded by Stephen T. Brown, and carried.

On motion of Chairman Little, seconded by Charles Richardson, Sr., and carried, the reference committee report (Section 9) pertaining to the Committee on Veterans Affairs was adopted.

Chairman Little moved for adoption of the reference committee report (Section 10) concerning the report, with addendum, of the Delegates to the American Medical Association. The motion was seconded by John W. Turner, and carried.

Chairman Little moved for adoption of the reference committee report (Section 11) concerning the resolution of A. H. Letton. The motion was seconded by Clarence B. Palmer, and carried.

Chairman Little moved for adoption of the reference committee report (Section 12) dealing with the resolution presented by Lester Rumble on medical care to veterans. Although seconded by W. F. Reavis, the motion failed to carry.

E. N. Burson moved that the Rumble resolution be tabled. The motion was seconded by W. L. Pomeroy, and carried.

The reference committee report as amended was adopted as a whole on motion of Chairman Little, seconded by W. F. Reavis, and carried.

New Business

Speaker Thomas W. Goodwin called for the introduction of new business.

W. F. Reavis moved that the House of Delegates consider the appointment of a Committee on Hospitals, composed of medical school deans and one member from each Congressional District in the state, with the President and Secretary as ex officio members. The Committee would study and help rural hospitals and would be separate and distinct from the standing Committee on Medical Education and Hospitals. The motion was seconded by Ralph Chaney, and carried.

W. F. Reavis moved that the House of Delegates consider creation of a standing Committee on Veterans Affairs, comprised of three members, with the President and Secretary as ex officio members. The President would appoint the three members to serve three, two and one year periods. J. B. Kay seconded the motion, which carried.

Allen H. Bunce emphasized to the House that creation of standing committees would fall to the consideration of next year's Committee on Constitution and By-Laws for inclusion in the By-Laws at the 1954 Annual Session.

There being no further business, upon motion duly made and seconded, the meeting was adjourned at 4:30 p.m. until Wednesday, May 13, 12:00 noon.

Wednesday Morning, May 13

The morning scientific program ensued in essentially the following order:

9:00 PANEL DISCUSSION:

Gold Room, Hotel DeSoto.

"Insurance Plans and Problems in Georgia."

Moderator: Mr. H. B. Coolidge, Savannah, Director, Physicians' Service Association of Savannah. Discussors: W. S. Dorough, Atlanta; W. F. Pomeroy, Waycross; John Elliott, Savannah; J. Z. McDaniel, Albany.

9:00 **CLINICAL SESSION:**
Grand Ballroom, Hotel DeSoto.
Presiding: Rudolph F. Bell, Thomasville.

SYMPOSIUM:
"Urology in General Practice."

9:00 "Undiagnosed, Gross Upper Urinary Tract Bleeding", Alex L. Finkle, Charles L. Prince and Peter L. Scardino, Savannah.

"Management of Urinary Calculi", James H. Semans, Atlanta.

Discussors: Peter L. Scardino, Savannah; Duncan Shepard, Atlanta, Wallace L. Bazemore, Macon; W. H. Bennett, Atlanta.

"Psychiatric Sequelae of Severe Head Injuries", Joseph D. McElroy, Atlanta. Discussors: Richard B. Wilson, Atlanta; Joseph S. Skobba, Atlanta.

"Pre- and Postoperative Management, One Stage Total Adrenalectomy: Report of Four Cases", Thomas A. McGoldrick, Jr., Savannah. Discussors: William F. Goodyear, Atlanta; W. E. Barfield, Augusta.

11:00 **CLINICAL SESSION:**
Grand Ballroom, Hotel DeSoto.
Presiding: James H. Semans, Atlanta.

"Controversial Aspects of Late Pregnancy Bleeding", Duncan E. Reid, Boston, Mass.

"What to Expect of the Photofluorogram", Sydney Jacobs, New Orleans, Louisiana.

"Progress in Georgia Civil Defense Health Services", Edgar M. Dunstan, Atlanta.

Final Meeting, House of Delegates

Wednesday, May 13

The meeting of the House of Delegates was called to order by Speaker Thomas W. Goodwin at 12:00 noon in the Grand Ball Room, Hotel DeSoto, Savannah.

Upon motion duly made and seconded, roll call and reading of minutes were dispensed with.

There being no unfinished business, Speaker Goodwin declared the introduction of new business to be in order.

Councilor George R. Dillinger presented the following resolution:

"WHEREAS, The past two years, the Annual Session of the Medical Association of Georgia has been conducted on a section basis and there has been much favorable comment,

THEREFORE BE IT RESOLVED, That the Committee on Constitution and By-Laws be requested to consider for introduction at the next Annual meeting amendments to the By-Laws, creating sections similar to those of the American Medical Association."

Upon motion duly made and seconded, the resolution was accepted.

President C. F. Holton read the following resolution:

WHEREAS, The medical profession and therefore the Medical Association of Georgia is dedicated to the protection of the health and physical welfare of humanity; and

WHEREAS, The recent publicity and advertisements of the Speers Chiropractic Clinic of Denver, Colorado proclaiming miraculous cures for cancer, polio, cerebral palsy and other diseases has caused both physical and financial distress among numbers of distraught Georgia families franti-

cally exhausting every possibility of medical assistance for family members suffering from any of the aforementioned conditions;

THEREFORE, BE IT RESOLVED, That the Woman's Auxiliary to the Medical Association of Georgia call to the attention of the Medical Association of Georgia the far reaching influence of false hope stimulated through misleading and false statements in the press and respectfully request that consideration be given by the Medical Association of Georgia to proper procedure to preclude further public abuse to the citizens of this state both by the Speers Chiropractic Clinic of Denver, Colorado and the newspapers; and

That a copy of this resolution be spread upon the minutes of the Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia this 11th day of May 1953; and

That a copy be submitted to the Annual Convention of the Medical Association of Georgia now in session for consideration and any action deemed advisable.

On motion duly made and seconded, the resolution was accepted for information of the House of Delegates.

President Holton read communications received by him from Mr. Lewis B. Wilson, Mayor of Macon, and Mr. Ellsworth Hall, President, Macon Chamber of Commerce, extending invitations to the Medical Association of Georgia to hold its 1954 Annual Session in that city.

It was moved by Sam Patton, seconded by Carter Smith, and carried, that the invitations be accepted.

Councilor W. Bruce Schaefer moved, President Holton seconded, and carried, that a resolution of gratitude be transmitted to Central of Georgia Railway Company and all other Savannah agencies which contributed to the success of the 1953 Annual Session.

On motion, duly made and seconded, the meeting was declared adjourned at 12:10 p.m.

General Membership Meeting

Wednesday, May 13

The meeting was called to order by President Holton at 12:10 p.m. in the Grand Ball Room, Hotel DeSoto, Savannah.

Warren B. Matthews, Atlanta, of the Georgia Association of Pathologists, spoke briefly about the recently-passed Georgia Post Mortem Examination Act and its affect on the medical profession.

Chairman Mark S. Dougherty, Jr. of the Committee on Awards with pertinent remarks, then presented a Certificate of Appreciation to President Holton on behalf of the Medical Association of Georgia, and for which President Holton expressed much gratitude.

Chairman C. L. Ayers of the Committee on Tellers then came to the podium and announced the names of officers elected by members of the Medical Association of Georgia:

President-Elect—Peter B. Wright, Augusta

First Vice-President—James C. Metts, Savannah

Second Vice-President—Milford B. Hatcher, Macon

AMA Delegate—Charles Richardson, Sr., Macon

AMA Alternate—C. L. Ayers, Toccoa

Councilor, Fifth District—Mark S. Dougherty, Jr., Atlanta
Councilor, Sixth District—H. Dawson Allen, Jr., Milledgeville

Councilor, Seventh District—D. Lloyd Wood, Dalton

Councilor, Eighth District—Neal F. Yeomans, Waycross

Vice-Councilor, Fifth District—J. G. McDaniel, Atlanta

Vice-Councilor, Sixth District—H. G. Weaver, Macon

Vice-Councilor, Seventh District—Ralph W. Fowler, Marietta

Vice-Councilor, Eighth District—James M. Hicks, Brunswick

Chairman C. L. Ayers thanked members for their cooperation in ballot casting, explained procedures followed by his Committee on Tellers, and expressed gratitude to Mrs. Stewart Roberts, Atlanta, for excellent assistance she rendered the Committee as secretary of the ballot box.

President-Elect Peter B. Wright, accompanied to the podium by retiring First Vice-President Rudolph Bell, expressed gratitude to the members for their vote of confidence

and pledged his untiring efforts in behalf of the Association. AMA Delegate Charles Richardson, Sr., accompanied to the podium by Thomas L. Ross, Jr., expressed thanks to members for their vote of confidence.

In turn, First Vice-President James C. Metts and Second Vice-President Milford B. Hatcher came to the podium to express appreciation for the honor bestowed on them.

C. F. Holton then officially presented the president's gavel to President William P. Harbin, Jr., who expressed gratitude for the honor awarded him and pledged whole-hearted support to the Association and membership.

The meeting adjourned at 12:55 p.m.

Wednesday Afternoon, May 13

The concluding afternoon scientific program ensued in essentially the following order:

2:00 OBSTETRICS AND GYNECOLOGY:

Gold Room.

Presiding: George A. Williams, Atlanta.

"Management of the Diabetic Patient in Pregnancy", Duncan E. Reid, Boston.

"Use of Trilene as an Obstetrical Analgesia", Seymour P. Weinberg, Atlanta. Discussion by Lester Rumble, Jr., Atlanta.

"Pelvic Evisceration for Advanced Cancer of the Cervix", Sam A. Wilkins, Jr., Emory University. Discussors: John H. Ridley, Atlanta; G. P. McInnes, Augusta.

"Loss of Life Occurring in Relation to the Reproductive Process", Helen W. Bellhouse, Atlanta, and H. F. Sharpley, Jr., Savannah. Discussors: Robert B. Martin, Cuthbert; E. D. Colvin, Atlanta; R. L. Johnson, Douglas, C. M. Mulherin, Augusta; Fred H. Simonton, Chickamauga (Members, Committee on Material Welfare).

2:00 INTERNAL MEDICINE:

Sapphire Room.

Presiding: Thomas L. Ross, Macon.

"Hypersensitivity Reaction to Procaine Penicillin . . . Anaphylactic Shock, Acute Ulcerative Cystitis and Acute Ulcerative Colitis", Robert L. Whipple, Jr., Atlanta. Discussors: William F. Friedewald, Atlanta; J. H. Hilsman, Atlanta.

"Hypersplenism with Pancytopenia: Report of a Case", Mark S. Dougherty, Jr., Atlanta. Discussors: Darrel Ayer, Atlanta; Fenwick T. Nichols, Jr., Savannah.

"Coronary Insufficiency or Failure", Lamont Henry, Atlanta. Discussors: Thomas L. Ross, Jr., Macon; C. Purcell Roberts, Atlanta.

Newer Advances in Chemotherapy of Lymphoma", Tully T. Blalock, Atlanta. Discussors: George Hutto, Columbus, Milton H. Freedman, Atlanta.

"Continuous Treatment of the Nephrotic Syndrome in Children with ACTH", Arthur J. Merrill, Atlanta. Discussors: Roger W. Dickson, Atlanta; Don F. Cathcart, Atlanta; James P. Hanner, Atlanta; T. Bolting Gay, Atlanta.

2:00 THORACIC DISEASES:

Chatham Room.

Presiding: John L. Elliott, Savannah.

"Diabetes and Tuberculosis", Sydney Jacobs, New Orleans, La.

"Pneumoconiosis in Soft Coal Workers", Louis L. Friedman, Birmingham, Alabama.

"The Management of Thoracic Trauma", James L. Alexander, Savannah.

"Present Status of the Isoniazid Therapy Study Program", H. E. Crow, Rome. Discussors: Rufus F. Payne, Augusta; John L. Elliott, Savannah.

"The Medical Profession—Responsibility to Tuberculosis Patients: A Public Health Viewpoint", H. C. Schenck, Atlanta. Discussors: C. C. Aven, Atlanta; Clarence W. Mills, Atlanta.

"The Therapeutic Response of Surgical Resection in Pulmonary Tuberculosis: A Study of One Hundred Cases", W. E. Van Fleit, Emory University. Discussors: Robert G. Ellison, Augusta; Samuel E. Patton, Macon.

"The Management of Obstruction to the Outflow Tract of the Right Ventricle", William A. Hopkins and Osler A. Abbott, Emory University. Discussors: Robert C. Major, Augusta; Harry T. Harper, Augusta.

"Technique of Operation for Pulmonic Stenosis" (Film), Hopkins and Abbott.

Official Registration, 103rd Annual Session, Hotel DeSoto, Savannah, May 10-13, 1953:

Members	623
Guests	69
Exhibitors	106
Total	798

Roundup on

AMA HOUSE OF DELEGATES

102nd Annual Meeting, New York City, June 1-5, 1953

The House of Delegates of the American Medical Association, in session at the Waldorf-Astoria Hotel during the 102nd Annual Meeting of the A.M.A. in New York City, took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

The House also named Walter B. Martin of Norfolk, Virginia, as president-elect of the American Medical Association for the coming year. Dr. Martin will become president at the June, 1954 meeting in San Francisco, succeeding Edward J. McCormick of Toledo, Ohio, who took office at a special inaugural session of the House of Delegates in the Hotel Commodore during the New York meeting.

The New York meeting was the largest ever held in the history of the American Medical Association, with the final figures on total attendance expected to reach or surpass 40,000, including nearly 18,000 physicians.

Giving unanimous approval to a recommendation from its Reference Committee on Insurance and Medical Service, submitted as a substitute for eight different resolutions concerning the treatment of non-service-connected disabilities by the Veterans Administration, the House adopted the policy that such treatment should be discontinued except in cases involving tuberculosis or psychiatric or neurological disorders.

In taking this action, the House reaffirmed and adopted the following recommendation originally presented at the Denver Meeting last December by the Special Committee on Federal Medical Services:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the A.M.A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. "Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as

represented by the American Medical Association.”

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

“Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy.

“The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly.

“Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee.”

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine were as follows:

“1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of ‘cultist’ handling.

“2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

“3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

“4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body.”

A minority report of the reference committee

urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately won out, included the following recommendations by the Board of Trustees:

“Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

“Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

“1. Should modern osteopathy be classified as ‘cultist’ healing?”

“2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

“3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?”

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December, 1952 meeting. The Reference Committee on Medical Education and Hospitals recommended a substitute resolution which was adopted by the House after considerable discussion. The action abolishes the rule whereby approval may be withdrawn from an internship program which for two consecutive years fails to obtain at least two-thirds of its slated complement of interns. The resolution also calls for further study of the Essentials by a committee appointed by the Speaker of the House, at least half of whom are doctors in private practice not connected with medical schools or affiliated hospitals.

Among the many other actions taken, the House reaffirmed its endorsement of the principles embodied in Senate Joint Resolution No. 1 concerning international treaties or agreements which interfere with domestic laws or rights, and it approved a resolution deploring a derogatory article about the American Medical Association which appeared recently in the Home Life Magazine. The latter resolution was referred to the Board of Trustees for implementation.

Highlights of the opening day session of the House were addresses by Louis H. Bauer, who delivered his term-end report as retiring president; Edward J. McCormick, who spoke on that day as president-elect, and Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare, and selection of the winner of the 1953 Distinguished Service Award.

Dr. Bauer, referring to charges of unethical practices among some doctors, declared that all members of the medical profession “should not be tarred with the same stick.”

Dr. McCormick outlined a nine-point program for further improvement in the nation’s medical care and expressed the hope that “their further development will solve many of medicine’s problems and eliminate much of the criticism to which we are subjected.

Secretary Oveta Culp Hobby of the Department of

Health, Education and Welfare told the delegates that the present administration in Washington is looking with confidence to the nation's physicians for leadership in meeting the challenge of modern medical care problems.

The 1953 distinguished Service Award was voted to Dr. Alfred Blalock of Baltimore for his outstanding work in vascular surgery and his part in the development of the so-called "blue baby" operation. Dr. Blalock, chief surgeon at Johns Hopkins Hospital and professor of surgery at Johns Hopkins University School of Medicine, received the award during ceremonies preceeding the presidential inauguration Thursday night, June 2.

In addition to the selection of Dr. Martin as president-elect, the House also elected Dr. Carl H. Gellen-

thien of Valmora, New Mexico, to the office of vice-president. He succeeds Dr. Leo F. Schiff of Plattsburgh, New York.

Re-elected to office were:

Dr. George F. Lull, Chicago, secretary and general manager; Dr. J. J. Moore, Chicago, treasurer; Dr. James R. Reuling, Bayside, New York, speaker of the House of Delegates; Dr. E. Vincent Askey, Los Angeles, vice speaker of the House; Dr. Edwin S. Hamilton Kankakee, Illinois, and Dr. Gunnar Gunderson, LaCrosse, Wisconsin, as member of the Board of Trustees.

The House elected Dr. Julian P. Price of Florence, South Carolina, to fill Dr. Martin's unexpired term on the Board of Trustees.

EUSTACE A. ALLEN

Georgia Physicians Registered

at New York AMA Session, June 1-5

ATLANTA

Robert H. Brown
T. E. Hodgins, Jr.
Edward M. West
Eustace A. Allen
John S. Atwater
Allen H. Bunce
Avery Dimmock
J. K. Fancher
Charles Joel, Jr.
Chris McLoughlin
Carl C. Aven
Jack K. Bleich
A. H. Germain
L. F. Hamff
Albert Heyman
Harold B. Levin
H. W. Minor
L. N. Turk, Jr.
John W. Whitney
Rufus A. Askew
Amey Chappell
Glenville Giddings
Jack M. Levin
Wyman P. Sloan
H. S. Weens
Louis Berger
Charles F. Cooper
E. B. Hecht
John R. McCain
George S. Roach, Jr.
W. W. Buckhaults
Howard Hailey
Vernon B. Link
William L. Dobes

SAVANNAH

George H. Faggart
Frank Hoffman
Milton Mazo
W. D. Wilson
Hollis E. Puckett
Vincent J. Cirincione
L. J. Rabhan
Frank K. Neill

ALBANY

Clarence J. Sapp
F. A. Blalock
William P. Harbin
Ralph J. Davis

MARIETTA

A. H. Fowler
Ralph W. Fowler
Ervine P. Inglis

AUGUSTA

Robt. B. Greenblatt
Lawton Q. Hair
Jack H. Levy

JESUP

Una R. Leomans
J. W. Yeomans

WAYCROSS

Vilda Shuman
Neal F. Yeomans

MACON

Max Mass
R. M. Reifler
Charles H. Richardson
Henry H. Tift
Edwin R. Watson

MISCELLANEOUS

George H. Alexander,
Forsyth
W. J. Gower, Thomaston
Lester M. Petrie, Decatur
Eli A. Rosen, Dalton
Edward C. Whatley, Reynolds
Mercer Blanchard, Columbus
Charles H. Watt, Thomasville
R. L. Denney, Carrollton
Benjamin Goldman, Hazlehurst
I. R. Berger, Chamblee
J. H. Pritchett, Jr., Monticello
H. J. Copeland, Griffin

Report of

EDITORIAL BOARD

Meeting, Savannah, May 11, 1953

A dinner meeting of the Editorial Board of the *Journal of the Medical Association* was held May 11, 1953 at the Oglethorpe Club, Savannah. Members present were: David Henry Poer, Editor, Atlanta; Charles L. Prince, Savannah; Robert C. Major, Augusta; Arthur J. Merrill, Atlanta; Charles W. Hock, Augusta; E. L. Bishop, Atlanta; Ted F. Leigh, Atlanta; A. G. Little, Jr., Valdosta; Henry H. Tift, Macon; C. F. Holton, Savannah; William Harbin, Rome; Lester Rumble, Jr., Atlanta; Herbert S. Alden, Atlanta; Mr. Sid Wrightsman, Jr., MAG Executive Secretary, Atlanta; and Mr. Milton D. Krueger, *JMAG* Managing Editor, Atlanta.

Guests at the Board meeting included Col. Joseph R. Shaeffer, MC, USA, Washington, D. C., and Mr. Ernest R. Gibson, *Journal of the Florida Medical Association*.

Mr. Ernest R. Gibson gave an address entitled "What Makes a Good State Medical Journal" which was to be presented by Shaler Richardson, Editor, *Journal of the Florida Medical Association*, whose absence was due to an unexpected illness.

After this address the Editorial Board discussed and considered certain problems of *Journal* policy and the following action was taken:

(1) Recommended that the *Journal* Editorial Board be organized according to professional specialties to facilitate critique of material considered for publication in the *Journal*.

(2) Approved the policy of having all editorials

appearing in the *Journal* remain unsigned by the author.

(3) Recommended that a monthly post card or letter be sent each member of the Editorial Board to stimulate the writing of material and procuring of material for the *Journal*.

(4) Recommended that the President's Page be continued as a regular feature of the *Journal* at the discretion of the MAG President.

(5) Recommended that a series of articles be carried in the *Journal* on the financial and economic aspects of the medical profession.

(6) Approved the policy of having all book reviews remain unsigned by the reviewer.

(7) Recommended that the Association monthly newsletter not be run in the *Journal*, but should remain a separate function of the Association headquarters office.

(8) Recommended that more pictorial matter be run in the *Journal* contingent on the financial income of the *Journal*.

(9) Approved the policy of referring to doctors by their given name only, thus deleting the Dr. that appears in front of their name. Any name appearing in the *Journal* that does not refer to an M.D. will be preceded by Mr. or be designated Ph.D., as the case may be.

A vote of thanks was given Mr. Ernest R. Gibson and Shaler Richardson for their splendid presentation and the meeting adjourned at 9:00 p.m.

AMA Aids in TV Show

"M.D."—a new five-minute television series produced by F. William Hart in cooperation with the American Medical Association, will be aired beginning Monday, June 1, over all 45 NBC-TV stations. This 26-week series will be presented as a public service by the National Broadcasting Company and E. R. Squibb & Sons. Featuring valuable health tips from "your family physician and his county medical society," the program will be presented as a five-

minute portion of the Dave Garroway "Today" show every Monday morning at 7-9 a. m. (EDST and CDST).

As the cooperating agency in the production of the series, the AMA clears all scripts, reviews the films and passes on all national sponsors. Whenever the programs are televised locally, the county medical society will have the right to approve local sponsors.

SOCIETIES

Fourth District Medical Society met June 10 at 7:30 p.m. at the LaGrange Country Club, LaGrange. J. C. Hughston, Orthopedist, of Columbus, was the guest speaker at the meeting.

Muscogee County Medical Society unanimously voted that all member physicians will contribute their emergency services to the recent storm victims the night of that disaster. This action was taken at their April 29 meeting. Principal speaker of the meeting was Isadore Lampe, professor of radiology at the University of Michigan Medical School. The subject of his address was "The Treatment of Cancer of the Female Genital Organs."

Edward Storey, chairman of the pharmaceutical committee reported a successful meeting with members of the local pharmaceutical society. William J. Peeples, assistant city-county health commissioner reported on the supply of gamma globulin assigned

to that area. A resolution was passed by the society endorsing the passage of a bond issue to permit the enlargement of facilities at City Hospital.

Ware County Medical Society met May 8 and heard Jack Bowen, Jacksonville dermatologist, discuss the four most common types of skin disease.

Ansley Seaman and Samuel Victor were hosts at the supper meeting which was held at the Waycross Golf Club.

The Georgia Society of Ophthalmology and Otolaryngology has elected the following officers for 1953-54: W. Eugene Matthews, Augusta, President; J. Kirk Train, Savannah, Vice-President; and Alton V. Hallum, Atlanta, Secretary-Treasurer. The Society's spring meeting in 1954 will be held on March 5-6 at the General Oglethorpe Hotel, Savannah.

The Georgia Urological Society has elected the following officers for 1953-54: James L. Pittman, Atlanta, President; J. Robert Rinker, Augusta, President-Elect; and J. Z. McDaniel, Albany, Secretary-Treasurer. Chairman of Arrangements for the 1954 meeting will be Charles L. Prince, Savannah.

PERSONALS

Formally honored on June 19 was *Frank K. Boland*, of Atlanta, at the dedication of the Frank K. Boland building at the Milledgeville State Hospital, Milledgeville.

Construction has started on an office building to be occupied by *A. M. Boozer* and *Paul Bradley*, of Dalton. Each of these physicians will have separate offices and separate waiting rooms in the one-story building located at Waugh and Selvidge streets, Dalton. Completion date is scheduled for sometime in August.

Director of Venereal Control *C. D. Bowdoin*, of the Georgia Department of Public Health, received the Ware County Cup Award for "outstanding achievements in the field of public health, particularly for his work in venereal disease control."

Braswell E. Collins, formerly of Waycross, announces the removal of his office from Waycross to 959 Daisy Park, Macon. His practice will be limited to diseases of the eye, ear, nose and throat.

David B. Dennison, announces the removal of his office on June 1st. to 1208 West Peachtree Street, N. W., Atlanta, with a practice limited to internal medicine.

Recently returned from Korean duty as a front line Army surgeon, *Faust Durden*, of Monroe, plans

to return to Grady Hospital, Atlanta, to complete his remaining year of surgery internship there.

Meriwether County's *R. B. Gilbert* has been moved from an Atlanta hospital to the home of his son in law and daughter in Hogansville to complete his recuperation from a recent illness.

Medical College of Georgia Professor *Robert B. Greenblatt* discussed the cost of adequate medical care at a Kiwanis club luncheon meeting May 18, held in Augusta.

J. E. Griffith, of Rockmart, who is Lockheed Georgia Division chief plant physician, has been promoted to the rank of colonel in the Air Force Reserve.

The Pike County Lions club presented a 50-year service plaque to *M. M. Head*, of Pike County, in recognition for his medical service to the community for the past 50 years.

Sage Harper and *Mrs. Harper*, of Douglas, announce the birth of a son on May 7.

Recently elected president of the Georgia Society of Clinical Pathologists was *Lee Howard, Jr.*, of Savannah.

John Paul Jones announces the removal of his office to 883 Pine Street, Macon. His practice is limited to pediatrics.

J. Morgan Kellum, of Thomaston, has recently returned from Chicago where he took a course in Fractures at the Cook County Graduate School of Medicine.

C. Lombard Kelly, retiring president of the Medical College of Georgia, was paid tribute at a recent meeting of the alumni in Savannah. A resolution citing his services to the school was read and he was presented with a silver tray by *Milford Hatcher* of Macon.

Speaking before the Canton Lions club, *J. H. Kite*, of Atlanta, on May 21, showed pictures and discussed children whom the Scottish Rite Hospital has helped.

D. S. Middleton, of Rising Fawn, suffered a broken rib and injury to his knee when his automobile failed to hold its parked position in his driveway and rolled into him. He returned to his practice immediately stating "I've treated worse cases than my own—and I don't want to neglect my practice."

Floyd W. Morgan, of Douglasville, has moved his offices from the Pounds Building on Campbellton Street to the old G. W. McLarty residence which has been remodeled into a suite of offices for the care of his patients.

E. V. Patrick, of Carrollton, was the guest speaker at the May meeting of the Sand Hill Ruritan club. The topic of the address was the history of medicine and its progress in the past 50 years.

Louisville physician *James W. Pilcher* was recently injured when his light airplane crashed into a small lake near Wrens. He was not believed seriously hurt as cuts and bruises were the only apparent injuries.

Lt. Fincher C. Powell, MC, USNR, of Decatur, took over duties as assistant chief of medicine at the 1,000 bed U. S. Naval Hospital at Camp LeJeune, N. C.

Invitation booklets, announcing the graduating class of the Emory University School of Medicine were dedicated this year to *Arthur P. Richardson*, associate dean of the School of Medicine, and *John B. Cross*, chairman of the department of obstetrics and gynecology.

Warning that the socialization of medicine is merely

the first step in the socialization of the economy of the country, *Peter L. Scardino*, of Savannah, gave an address to the Savannah Lions club on that subject.

Hahira physician *E. J. Smith* was honored May 6, for his service to the community for the past 52 years. Friends and neighbors all paid tribute at the Tower Community clubhouse near Hahira.

David E. Tanner, of Sparta, has purchased the Sparta Methodist parsonage which he plans to have converted into a modern clinic with offices on the first floor and patient's rooms on the second floor.

Two Augusta psychiatrists, *Corbett H. Thigpen* and *Harvey M. Cleckley* presented a case report at the American Psychiatric Association meeting recently and received national play in the newspapers of the nation.

The Hospital Authority of Albany and Dougherty County announced the appointment of *Frederick Haller Thompson*, formerly of Atlanta, as pathologist for Phoebe Putney Hospital.

Robert L. Whipple, Jr., and *Daniel D. Hankey* announce their association for the practice of internal medicine at the Medical Arts Building, Atlanta.

R. Hugh Wood, dean of Emory University School of Medicine recently spoke to the health section of Metropolitan Atlanta Community Services. His subject was "Atlanta's Health Needs and Resources." *Eustace Allen*, of Atlanta, is chairman of the health section.

Daniel C. Elkin, of Atlanta, will retire from the faculty of Emory University at the end of the 1953-54 academic year. He has been professor of surgery and chairman of the department of surgery in the Emory School of Medicine for 23 years.

Appearing currently in the June 13 issue of the *Journal of the American Medical Association* is the article "Meconium Peritonitis" which was written by *Herbert M. Olnick* and *Milford B. Hatcher*, of Macon.

DEATHS

BROWNING: *Zack Browning*, 36, of Augusta, died unexpectedly in his home May 2. He was the University Hospital resident in orthopedics.

FISCHER: *Luther C. Fischer*, 81, of Atlanta, died April 29 of a cerebral hemorrhage. Founder of Atlanta's Crawford W. Long Hospital, he was president and treasurer of the hospital at his death. A graduate of the Atlanta College of Physicians and Surgeons in 1899, he devoted his life to service. His will stipulated that the bulk of his estate be used in the care of indigent patients.

FORT: *Mannie A. Fort*, 80, of Bainbridge, died May 9 following an illness of seven weeks. One of Decatur County's best known physicians, he died three days before he was to have been presented with a 50-year Certificate of Service by the Medical Association of Georgia. A graduate of Tulane University of Louisiana School of Medicine in 1903, he practiced in Bainbridge 29 years. He was also awarded an honorary degree of Doctor of Public Health by the Medical College of Georgia for his outstanding contribution to that field.

STATON: *Torrence R. Staton*, 44, of Atlanta, died May 7 when his light plane crashed five miles northeast of Forsyth. A graduate of Emory University School of Medicine in 1930, he had specialized in urology and surgery.

When organisms resist the other

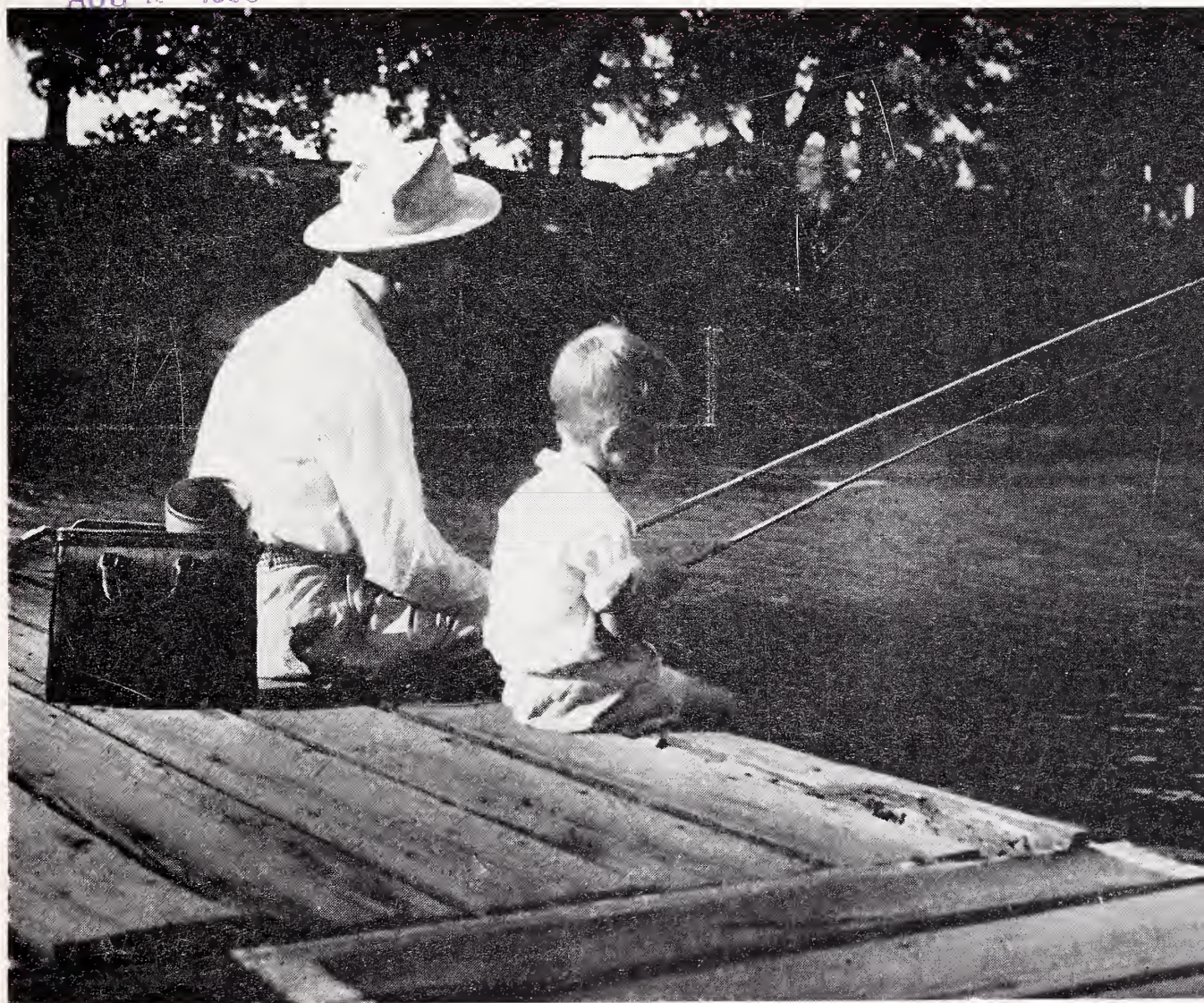


JOURNAL of The Medical Association of Georgia

JULY • 1953

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(1) Krantz, J. C., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Baltimore, The Williams & Wilkins Company, 1949 (Reprinted 1950), p. 518. (2) *ibid*, p. 515. (3) Carter, S.: Epilepsy, in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 612. (4) Salter, W. T.: A Textbook of Pharmacology, Philadelphia, W. B. Saunders Company, 1952, p. 231.



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The JOURNAL
of the
MEDICAL
ASSOCIATION
OF GEORGIA

875 WEST PEACHTREE, N.E.
ATLANTA, GEORGIA

JULY, 1953

VOLUME NUMBER 7



Photo by Ted F. Leigh, M.D.

Perhaps it's on a Wednesday or Thursday afternoon or maybe there's even time for a bona fide vacation away from the cares and wear of a physician's busy daily practice. The cover picture reminds us that the doctor, as Everyman, enjoys "just fishin'."

Our cover is dedicated to the physician and his family — and a pleasant vacation for them this summer.

Special attention is called to the editorial on the "Prompt Reporting of Poliomyelitis Cases" which is carried in this issue. With the advent of the polio epidemics in Montgomery County, Montgomery, Ala., and Caldwell County, Lenoir, North Carolina, this article is timely and carries a vital message for Georgia physicians.

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The JOURNAL of the Medical Association of Georgia

PLAN NOW FOR YOUR 1954 ANNUAL SESSION IN MACON MAY 2 - 5, 1954

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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MEDICAL EDITING SERVICE. If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.



The Magazine

Official Newsletter of the
Medical Association of Georgia
875 W. Peachtree St., N.E.
Atlanta, Ga.

'POWER THAT BE' SUGGEST TRY-OUT via this medium for official MAG newsletter, result of which purportedly may increase "readability" of both . . . Arguments opposing *JMAG*-published newsletter go like this:

. . . Untimely news because of prolonged time-lapse between incident occurrence and *JMAG* publication-distribution dates.

. . . "Dirty linen display" should be avoided in publication as widely distributed and pursued abroad as *JMAG*.

. . . If you've an expression on the matter, notify MAG headquarters office!

MARK-OFF MAY 2-5 DATES ON YOUR '54 CALENDAR for the 104th Annual Session at Macon . . . Macon Chamber of Commerce mainly responsible for date-switch from traditional second to first May week-end because of torrid temperatures in evidence from then on.

. . . Hotel reservations to be handled by Bibb County Society committee, and the Hotel Dempsey has been designated as "headquarters."

. . . W. R. Golsan, Macon, designated as Local Arrangements Committee Chairman and H. Dawson Allen, Jr., Milledgeville, was designated chairman of the Council Committee on Arrangements . . . Chairman Golsan stated on June 10 that he had every confidence that Macon could "well take care of" the '54 Session.

POST-CONVENTION QUESTIONNAIRES SENT ALL PARTICIPANTS in the '53 Savannah Session to determine existing "gripes" as well as information on convention's good points . . . Of 75 forms distributed, 31 (some signed, some unsigned) have been returned, with majority indicating the '53 Session to have been "the best yet."

. . . Generally conceded that overly-crowded scientific programs were disadvantageous to discussors, many of whom, having traveled great distances, were never recognized by watchful presiding officers, anxious to start and stop punctually their sections.

. . . One "unsigned" comment declared that morning attendance at general sessions could be improved by scheduling no programs prior to 11 a.m.

. . . "Doctors, after all, attend conventions to rest as well as to learn," the comment concluded. Do you have a comment or suggestion?

CHECK CAREFULLY OFFICIAL MAG COMMITTEE LISTING in Association section of this *JMAG* . . . If your name should appear but doesn't, contact MAG headquarters office immediately . . . For initial time since adoption of revised Constitution and By-Laws at '51 Session, term expiration dates are shown where necessary.

OFF TO AN ENTHUSIASTIC START, MAG PR Committee, under Chairman Chris McLoughlin's direction, held its initial meeting at Macon on July 12 to map-out specific PR goals for coming year . . . Plans include a "live" exhibit at Atlanta's Southeastern *Fair-a-ganza* October 1-10, possible public medical forums in other localities in the state, and a continued push for 24-hour emergency phone service in "logical" communities where yet untried.

EVER STOP TO REALIZE THAT ONE AMERICAN IN SIX is prospective recipient of medical and hospital care at Federal expense? . . . War veterans and servicemen's dependents, totaling approximately 20-million and 5-million respectively, comprise more than 90 per cent of this potential patient load.

IF NINTH DISTRICT MEDICAL SOCIETY MEMBERS fail to keep posted on goings-on in their neck-of-the-woods, it will hardly be the fault of District Secretary George T. Nicholson of Cornelia . . . With unstinting assistance from Mrs. Nicholson, he now issues a monthly mimeographed newsletter to all District members who, in turn, regularly supply him with news items about their respective county societies and local members . . . Written in a readably "breezy" style, the news sheet received written commendation recently from the AMA Public Relations Department.

SECOND ANNUAL REPORT OF THE AMERICAN MEDICAL EDUCATION (for 1952) is broken-down into two categories: (1) direct AMEF contributors (donations unspecified for specific medical schools), and (2) AMEF medical school contributions.

. . . Of 7,259 direct AMEF contributions, totaling \$906,533.83. 53 came from Georgia and amounted to \$11,407.50 (this sum including the \$10,000 MAG donation made at the '52 Session).

. . . 25' MAG members during 1952 made donations to specific medical schools.

. . . Report states that during '52 AMEF gave \$35,097 to Emory University School of Medicine and \$35,627 to the Medical College of Georgia from its general funds.

BY THE TIME THIS REACHES YOU, AMA no doubt will have expressed itself on Dr. Paul B. Magnuson's lengthy interview in the July 3rd issue of *U. S. News & World Report*, Article outlines his ideas about British medicine, doctors' fee in the country, "ghost surgery," etc, some of which are excellent, others debatable.

. . . Editors have since indicated that the questions were put to Dr. Magnuson over six months ago, immediately after he completed task as chairman for Truman's Commission on Health Needs of the Nation.

'TOP-FLIGHT TRI-STATE PG OBSTETRICAL SEMINAR, held annually for Georgia, South Carolina, and Florida physicians, has been set for September 14, 15, 16 at Daytona Beach's Sheraton-Plaza Hotel . . . Of particular interest to GPs, since AAGP credit hours are allowed, the seminar will mainly offer information on the newest trends in Ob and newborn infant care, with ample time allotted for questions and discussion.

TENNESSEE VALLEY MEDICAL ASSEMBLY

(Sponsored by the Chattanooga-Hamilton County Medical Society)

READ HOUSE • CHATTANOOGA, TENNESSEE

MONDAY, SEPTEMBER 28, and TUESDAY, SEPTEMBER 29, 1953

PROGRAM

MONDAY MORNING:

PHILIP THOREK, M.D., Chicago, Ill., "Acute Abdomen"
RICHARD W. TELINDE, M.D., Baltimore, Md., "Carcinoma of the Cervix"
PAUL D. WHITE, M.D., Boston, Mass., "Hypertensive Heart Disease a Generation Ago and Now"
CHARLES W. MAYO, M.D., Rochester, Minn., Alex Stewart Memorial Lecture "Colon Surgery"

MONDAY AFTERNOON:

PAUL D. WHITE, M.D., Boston, Mass., "Notes on Coronary Heart Diseases"
ROBERT B. LAWSON, M.D., Winston-Salem, N. C., "To Treat, or Not to Treat"
RICHARD W. TELINDE, M.D., Baltimore, Md., "Pelvic Endometriosis"
JOHN R. HELLER, M.D., Bethesda, Md., "Pathogenesis of Carcinoma"
Banquet Monday night, Mr. Leo Brown, Chicago, Ill., "Medicine's Golden Opportunity"

TUESDAY MORNING:

JOHN R. YOUMANS, M.D., Nashville, Tennessee, "Anemia and Nutrition"
RICHARD B. CATTELL, M.D., Boston, Mass., "Advances in Pancreatic Surgery"
H. EARLE CONWELL, M.D., Birmingham, Ala., "Some Do's and Don'ts in Fracture Treatment"
GEORGE CRILE, JR., M.D., Cleveland, Ohio, "Diseases of the Thyroid Gland"

TUESDAY AFTERNOON:

RICHARD B. CATTELL, M.D., Boston, Mass., "Surgical Treatment of Gastric and Duodenal Ulcers"
V. P. SYDENSTRICKER, M.D., Augusta, Ga., Subject to be announced
PAUL HOLBROOK, M.D., Tucson, Ariz., "Treatment of Rheumatoid Arthritis"
GEORGE CRILE, JR., M.D., Cleveland, Ohio, "Bleeding Esophageal Varices"

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In the Editor's Mail

To the Editor:

I want to express my appreciation for making it possible for several of us to explain the work of the Vocational Rehabilitation Division to the physicians at the recent meeting of the Medical Association of Georgia in Savannah. I had many compliments on our panel discussion, and I am sure that many of the doctors are more familiar with the program as a result of this.

It has been my privilege to attend a number of your meetings and I certainly concur with you and others that this was by far the best conference that I have attended.

We appreciate your interest in the Vocational Rehabilitation Division and wish to urge that you call on us at any time that we can be of service.

Sincerely yours,

A. P. JARRELL, Assistant Director
Vocational Rehabilitation
State Dept. of Education

To the Editor:

Thanks for your editorial in the May number of the *Journal of The Medical Association of Georgia* on "Professional Dignity." This is something that I have thought about a good deal when I have seen a tendency on the part of the younger members of the profession to sacrifice this thing which we call dignity for their personal comfort.

It seems to me a rather marked concession to laziness and weakness on the part of the members of the profession who should be strong enough to resist such things.

If one would visit the larger medical centers and the large clinics of this country I am sure he would find that all men on the staff wear collars and ties and practically all of them wear their coats.

I feel that this matter of getting over heated is largely a state of mind and I know from personal experience that one can overcome it. I feel proud of the fact that the title of Doctor of Medicine carries with it a certain amount of dignity and respect and I am willing to pay whatever price is necessary to uphold these standards.

Again, these sort of discussions are interesting and let's have more of them.

Very truly yours,

C. H. RICHARDSON, M.D.

To the Editor:

There are several points of reply to the editorial concerning professional dignity and the wearing of sport shirts appearing in the May, 1953, issue.

At best, a man dressed conventionally in hot weather looks and feels miserable. At worst, it could be actually detrimental to his well being. The medical profession still has the respect of the majority of the people and is looked to for leadership. Furthermore, as a professional man, he is not bound by the dictates of an employer. Therefore, it is logical for doctors to take the initiative in this matter and start the trend toward more sensible attire in summertime.

For too long the doctor has fallen back on "professional dignity" to the detriment of his relationship with his patients. Today there is much better response to the approach of being a friend and counselor who does not hold himself above the level of the people he treats and depends on for a living. No one will question a physician's learning or ability because he is dressed comfortably.

But most important of all is the fact that there are far more vital matters to be concerned with than the wearing of slacks and sport shirts. There is the commercialization of injections—liver, vitamins, estrogens, and antibiotics. There are unnecessary treatments, needless operations, ghost surgery, and excessive fees. There is the attitude that "everyone else does it, so I might as well." or the closely related "The patient is determined to have this procedure done. Why should I let the other man collect the fee?" Except for those shortcomings of the profession, full confidence in us by the public would soon be a reality. With their complete support it is probable that evils such as chiropractic and other cults could soon be eliminated. The correction of the above named faults certainly takes precedence over the wearing of informal clothing.

Therefore, while we personally favor the wearing of neat sport shirts for professional duties, we recognize the controversial nature of the subject. If first things are to be taken first, however, we feel that the matter will be dropped until some general housecleaning is done along other lines.

Sincerely,

JOHN E. BECK, M.D.

CHESTER W. MORSE, M.D.

(Editor's Note: As correct as the authors are concerning the major problems to be solved by the profession, we still feel that most patients prefer for their doctors to look the part.—DHP.)



Gastro-Intestinal Antispasmodics and Antisecretory Agents

Belladonna preparations and the pure belladonna alkaloids, particularly atropine, have been utilized for their antispasmodic effect upon the stomach and intestines and for their antisecretory effect upon the gastric secretory glands for many years and even today are still clinically useful agents. The most important pharmacologic effect of these agents is their ability to block stimuli induced by parasympathetic impulses at the junctions of the post-ganglionic sympatholytic effect). Unfortunately, the action of intestinal tract and the glands of secretion (paranerves supplying the smooth muscle of the gastro-atropine and related parasympatholytic agents is widespread and therefore not limited to the smooth muscle of the gastro-intestinal tract or the gastric secretory glands. They also reduce or obliterate completely the normal secretory function of the sweat, bronchial and salivary glands in addition to paralyzing the ciliary muscle of the lens and the sphincter muscles of the iris of the eye with resulting cycloplegia and mydriasis. In moderate doses these agents have little effect on the heart rate but when therapeutic levels are pushed or exceeded, tachycardia ensues.

In an attempt to reduce the incidence and severity of, or even eliminate, these other undesirable actions which are erroneously referred to as 'side-effects', synthetic derivatives of atropine as well as other synthetic antispasmodic and antisecretory agents have been investigated. Research in this field has proceeded along three distinct lines in the search for agents with more specific antispasmodic and antisecretory actions and the newer drugs may be put into three categories, namely: tertiary amine antispasmodics, quaternary amines with potent anticholinergic activity and ganglionic blocking agents.

Tertiary Amine Antispasmodics

In general, there are two types of antispasmodic agents; the neurotropic, which act on smooth muscle through nerve endings (atropine), and the muscletropic or myotropic, which produce relaxation by a direct action on smooth muscle (papaverine). There is available a group of agents classified as antispasmodics with little or no antisecretory activity but which possess some degree of both neurotropic and myotropic activity. Agents such as Trasparentin[®], Syntropan[®], and Pavatrine[®] belong to this group. Bentyl[®], is the newest and probably the most active agent in this group with a very low incidence of mydriasis, cycloplegia and xerostomia.

Quaternary Amines with Potent Anticholinergic Activity

Most progress in the field has been made in this group of agents. These agents possess a high degree of parasympatholytic activity approaching that of atropine in addition to some ganglionic blocking or synaptolytic action, although the effects produced with clinical doses are chiefly a result of the former action. As a result of the introduction of Banthine[®] (Methantheline) in the management of peptic ulcer (Propantheline) has been recently introduced on the basis of increased activity and a greater specificity with minimal side-effects. Of these agents, Antrenyl[®] (Oxyphenonium) is the most potent with a relatively low incidence of mydriasis and xerostomia. Compound 14045 (Lilly) and a number of closely allied agents are even now receiving clinical trials for their antispasmodic and antisecretory activity. Of the three groups of agents, this group possesses the most potent antispasmodic and antisecretory actions. Experimental studies in man have shown that the agents most effectively decreasing gastric secretion also tend to produce more side-effects.

Ganglionic Blocking Agents

Tetraethylammonium (TEA) and Hexamethonium have been shown to possess a marked inhibitory effect on gastro-intestinal motility and gastric secretion. However, here again, the action is not specific for the gastro-intestinal tract and the blockade of other ganglia leads to undesirable effects, such as postural hypotension, xerostomia, tachycardia and urinary retention. TEA also has a short duration of action. Prantal[®] (Diphenmethanil methylsulfate) is claimed to possess a more specific action on parasympathetic ganglia associated with gastric secretion and motility and has been introduced for the management of peptic ulcer. It also possesses some parasympatholytic activity but only occasionally produces mydriasis, xerostomia and urinary retention.

The clinical value of agents in the treatment of peptic ulcer and spasm of the gastro-intestinal tract depends not only upon their antisecretory and antispasmodic potency but also upon the incidence and severity of disturbing symptoms of parasympathetic inhibition. Some progress has been made in dissociating the undesirable actions from the therapeutically essential ones but further advances are anticipated chiefly in the field of the quaternary amines possessing potent anticholinergic activity.



The Bookshelf

REVIEWS

NERVOUS SYSTEM, VOLUME I, THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS: By Frank H. Netter, M.D.

This small volume which contains 104 full color paintings of the nervous system with a very concise descriptive text is an extremely valuable adjunct not only for those interested in the study of the nervous system but for those as well who might not be completely familiar with the anatomy. While it is brief and concise, the anatomical illustrations are extremely well done and give one the impression of a stereoscopic or third dimensional view which is so necessary in the teaching of neuroanatomy. The authors who have written the descriptive text have done so in a commendable and concise manner, making this book a very worthwhile addition to the library of the general practitioner or to the Intern Library for quick reference. While this book is by no means intended to be a text in its scope, it does serve as a valuable reference not only for neuro-anatomy but quite briefly for some of the pathological problems encountered in surgery of the brain and spinal cord.

ANATOMY OF THE NERVOUS SYSTEM: Ninth Edition, By Stephen W. Ranson and Sam L. Clark. W. B. Saunders Company, Philadelphia, 1953.

It is difficult to find anything original to say in reviewing a book which has been a recognized leader in its field for 30 years. This ninth edition represents no radical departure from the preceding one. Dr. Clark has added a number of excellent new figures which enhance and enliven the book from the standpoint of the beginning student and the Table of Contents has been amplified to make it much more usable.

A number of important additional references to recent research appear in the bibliography. These are reflected in the general improvement of the text which has shown in recent editions a strong trend toward the happy integration of a functional point of view with the traditionally sound morphological treatment which has characterized Ranson since its first edition.

In particular, the sections on thalamo-cortical relationships have been greatly enhanced by the inclusion of important information acquired in recent years by such workers as Magoun, Rose, Jasper and others, principally by electrophysiological methods. These studies provide a new and more workable approach to some of the most crucial problems in neurology which have perplexed those in the field

for many years. The student, as well as the investigator, should find it easier to acquire a grasp of the dynamics of brain function as a result of the exposition of this more sophisticated point of view.

There are additions to the material and interpretation on motor function, especially with respect to extrapyramidal systems. The treatment of autonomic system and function has been brought up to date by addition of theoretical considerations and a section on autonomic surgery.

On the whole, then, the Ninth Edition of Ranson-Clark represents an overall modernization and continuing shift of emphasis toward function without sacrificing any of the fundamental morphological accuracy on which the well-deserved reputation of this book has been based through the years.

DISEASE OF THE ESOPHAGUS by Philip Thorek, M.D. 102 illustrations, 140 pages. The J. B. Lippincott Co., Philadelphia. Price \$10.00.

"Diseases of the Esophagus" is a concise, well illustrated volume written by an author experienced in the diagnosis and management of lesions involving the esophagus. This book has been divided into twelve chapters, with the first four chapters being devoted to esophageal anatomy and physiology, special diagnostic methods and the general surgical considerations in the management of esophageal lesions. The remaining eight chapters discuss the diagnosis and management of specific lesions and processes directly or indirectly affecting the esophagus.

The introductory chapters of anatomy and physiology present in a brief, concise manner the applied anatomy and physiology of the esophagus as a contiguous portion of the gastro-intestinal tract. In subsequent chapters, these facts are again stressed in the diagnosis and management of specific esophageal lesions.

This book is well balanced, devoting major space to those disease processes commonly encountered, but, in addition, rare esophageal lesions are briefly described.

This book is recommended to both the practitioner and the surgeon, and should prove a valuable aid in the diagnosis and management of lesions of the esophagus. An excellent bibliography is included with this volume.

PHYSICAL EXAMINATION OF THE SURGICAL PATIENT. By J. Englebert Dunphy, M.D., F.A.C.S., Associate Clinical Professor of Surgery; and Thomas W. Botsford, M.D., F.A.C.S., Clinical Associate in Surgery, Harvard Medical School. W. B. Saunders Company, \$7.50.

This book is designed to focus attention on methods and importance of eliciting physical signs in

surgical conditions. The emphasis is placed on the methods of physical examination which are not so well covered in standard text books but which should be familiar to every physician. Students and practitioners must have a fundamental knowledge of the pathology and physiology of diseases if they are to use this book intelligently.

The book is written in a simple, informal manner of how to examine a patient and derive the most information by the simplest means. The authors emphasize that x-ray, laboratory and other diagnostic tests cannot be substituted for the examiner's eyes, ears, fingers, nose, and brain.

This book gives not only the detailed technique of examination but also the approach to the patient as an individual. The authors emphasize the establishment of good rapport with the patient and the practice of dignity, gentleness, and thoughtfulness in order to give the patient the impression that the doctor is interested in him not as a disease but as a

persons with a disease.

The material in this book is divided into two parts: The elective examination and the emergency examination. The first part is devoted to those features of elected physical examination primarily important in the recognition of surgical disease exclusive of those involving the eyes, ears, nose, and the heart and lungs. The second part gives the general principles in examination of the injured patient and goes into detail concerning injuries of the head, face, chest, abdomen, and extremities. The technique of taking a history is not within the scope of this book. The disease processes are discussed briefly in order to give meaning to the physical signs encountered. A check list for a physical examination is included in the appendix.

The book is an excellent guide for a student in diagnosis of surgical disorders. For the practitioner the book will refresh his mind in appraisal of surgical conditions.



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Council Names

MARK S. DOUGHERTY, JR.,



Mark S. Dougherty, Jr.

*of Atlanta, as MAG**Assistant Secretary-Treasurer*

Long active in Association affairs, Mark S. Dougherty, Jr., of Atlanta has been appointed Assistant Secretary-Treasurer of the MAG by the Council at their recent meeting June 14, 1953. The many complexities of the office of Secretary-Treasurer and the multitudinous details which must be handled by the Secretary-Treasurer make this new appointment vital to the effective organization of your Association. And the appointment becomes a happy reality when so able a man as Mark S. Dougherty, Jr., is chosen for this office.

Mark Dougherty, Diplomat of the American Board of Internal Medicine since 1940 and Fellow of the American College of Physicians, is a graduate of the University of Pennsylvania School of Medicine, 1926.

Having served as a Commander in the United States Naval Reserve, his tour of duty included two years in Charleston, South Carolina, six months in San Francisco, and one year in the Philippines. He was also an Associate in Medicine at Emory University School of Medicine.

How Many HILL-BURTON *Hospitals*

The question sometimes is heard from physicians and others as to how many hospitals constructed under the Hill-Burton Program have been closed since the operation of these new hospitals began. The printed hearings before the Subcommittee of the Committee on Appropriations of the U. S. House of Representatives for the 83rd Congress, First Session, supplies the first authentic statement that has come to our attention regarding this matter. These hearings were held during April, 1953. It is interesting to note that of the more than 1,100 hospitals and health centers that have been

Have Been CLOSED?

completed and put in operation since the beginning of the program in 1946, only three have been closed. One of these may be in operation by now. These three projects are as follows:

1. The Halifax County Community Clinic, Scotland Neck, N. C. This was a 20 bed facility. This clinic opened on March 15, 1950 and closed April 1, 1951. At the time the community clinic

opened there were three physicians. One of the physicians died, another moved away and the one physician left was unable to keep the clinic going. The North Carolina Medical Care Commission and the North Carolina State Medical Association are rendering assistance to the community in securing a physician and surgeon to practice there.

2. St. Luke's Hospital, Kearney, Nebraska. This project, from the standpoint of financial assistance, included only funds for the equipment. This hospital of 25 beds was opened July 10, 1950 and closed in the fall of 1951. It appears that the principal reason for closing the hospital was that it was not utilized by the physicians of the area.

3. Hancock County Hospital and Health Center, Sneedville, Tenn. This is a county health center and hospital combined in one building. The hospital part has 11 in-patient beds. According to the plan of operation, the county health officer is expected to operate both the health center and the hospital. The health center portion of the facility was opened November 1, 1951. The hospital part is not being utilized at present. The State Health Department

of Tennessee is attempting to correct this situation. The reason given for not opening the hospital part of this project is that it has not been possible to find a county health officer who would and could conduct both the county health work and the hospital.

Thus it will be noted that two of these three projects are essentially public health centers or community clinics and are not hospitals in the usually accepted sense of the word.

The fact must also be remembered in analyzing the construction program that many new hospitals constructed in Georgia have replaced sub-standard facilities. Qualified personnel from the closed hospitals have formed the nucleus of the staff for most of the new hospitals.

It is a remarkable record that only three of the more than 1,100 projects that have been constructed in the United States under the Hill-Burton Program have closed. It would be reasonable to assume that because of shifts in population and other unforeseeable factors, others will close in the future. With satisfaction we observe that none of the projects that have closed are in Georgia.

PROMPT REPORTING *of*

POLIOMYELITIS *Cases*

Poliomyelitis was a comparatively rare disease in the early years of this century. The annual case rate during the past 20 years, however, has been steadily upward and poliomyelitis is now recognized as a communicable disease problem in every State in the nation. In 1952 the case rate and the estimated death rate were the highest since the 1916 epidemic. In addition to the increasing attack rate of poliomyelitis, there has been a shift in the age incidence in recent years. Last year, for example, more than 25 per cent of patients were over 15 years of age.

There is reason to believe that doctors throughout the State of Georgia are not promptly reporting cases of poliomyelitis to the Health Department. The name, address, age, sex, color, and whether the patient has paralytic or non-paralytic poliomyelitis should be given the Health Department as soon as possible after diagnosis by the examining physician. Incomplete records and lax reporting make it impossible to promptly report Georgia statistics.

Such statistics are of vital importance. They are used by the Health Department and the National Foundation for Infantile Paralysis in long term studies of the various factors which influence the occurrence of this disease. Perhaps of more immediate significance is the fact that these statistics are used to determine the allotment of gamma globulin to the State Health Department. In the event of an epidemic the amount of immune globulin that a particular city or town might get would be based on an analysis of the information supplied by the attending physicians. For example, if only 10 per cent were paralytic cases, there would be less need for widespread use of gamma globulin than if 50 per cent or more of the cases were paralytic. Unless these statistics are complete and up to date, appropriate action cannot be taken.

May we urge every physician in the State of Georgia to cooperate by promptly supplying complete information on each case of poliomyelitis to the Health Department.

FUNDS *for* STATE-AID PROGRAM REDUCED

As a result of diminishing revenues, funds available for the state aid cancer program will be reduced at least \$40,000 during the current fiscal year. A saving of that amount can be accomplished only by reducing expenditures for hospital care.

This fact is further emphasized statistically because hospital care accounts for almost 75 per cent of the cost of the whole program. Further figures show that only 12 per cent is spent for x-ray therapy and lesser amounts for diagnostic x-rays, radium therapy and other services. Clinic physicians receive no compensation for their personal services.

In the problem of reducing the expenditure for hospital care, there is evidence to show that a few clinics are not too concerned with the length of time patients remain in hospitals. Certain services provided by these clinics during 1952 required an aver-

age hospital stay of 8.2 days as compared with a stay of 2.6 days for the remaining clinics.

It is important to point out that a reduction in the hospital stay of only an occasional patient would amount to a sizeable figure during the course of the year. If the average period of hospitalization is reduced only one day per patient, it will result in an annual saving of about \$15,000.

The Georgia state-aid program for indigent cancer patients is an important link in the health and welfare of the people of this state. It must not be jeopardized by this reduction in funds. The reduction can be accomplished without adversely affecting the program if certain clinics will give greater consideration to reducing the period of hospitalization.

TAKE YOUR PICK

Recently a neurosurgeon operated upon a patient whom I knew, and when I asked the surgeon what was the matter with the patient he replied that he had "Pick's disease." This surprised me because I had always thought that Pick's disease had something to do with the pericardium, and a neurosurgeon would not likely be treating it. Then the surgeon informed me that the Pick's disease he had in mind involved a degeneration of the brain, and always resulted fatally, which it did in this case in a few days.

Then a new dictionary told me that there are four diseases which go by the name of Pick's, and the Pick is a different individual in every case. Arnold Pick described the brain condition, which the dictionary says is a circumscribed atrophy of the brain; a form of dementia characterized by a progressive degeneration of the higher faculties and the development of aphasia.

The Pick's disease of F. J. Pick is known as erythromelia, and is marked by painless progressive redness of the skin, radiating from the central part of the periphery, and situated on the extensor surfaces of the legs and arms. The Pick's disease of Friedel Pick is polyserositis; a condition marked by

enlargement of the liver with peritonitis and obstinately recurring ascitis, but without jaundice, occurring in patients with a previous history of pericarditis. It is a form of multiple serositis and has been called *pericardial pseudocirrhosis of the liver*.

Fourthly comes the condition known as Niemann-Pick's disease, (Ludwig Pick), which is described as a disturbance of infantile phosphatide metabolism marked by anemia and leucocytosis with relative increase in lymphocytes, enlarged spleen and liver. The histiocytes throughout the body become filled with lecithin fat which gives them a foamy appearance. The disease runs a rapid course ending in death within the first two years of life. It is also called *lipoid histiocytosis*.

So evidently each of these diseases which bear the name of Pick is a separate entity, and the lexicographers should do something to unscramble such nomenclature. At the present time, you can take your Pick. Proper names applied to diseases have always been confusing, although it is only right that the person who first describes an entity should have it called by his name. The new dictionary lists more than 6000 diseases which bear the names of those who first described them.

Hypersensitivity Reaction to

PROCAINE PENICILLIN

ANAPHYLACTIC SHOCK,

Acute ULCERATIVE CYSTITIS, *and*

Acute ULCERATIVE COLITIS

ROBERT WHIPPLE, JR., M.D., Atlanta

Hypersensitivity reaction to penicillin, including fever, serum sickness-like reactions, and various skin rashes,^{1,2} occur with varying frequency and are well known. Fortunately, the more serious and unusual reactions are rare. Anaphylactic shock and even death have been reported on several occasions.^{3,4,5,6,7} Unusual manifestations and pathological evidence of hypersensitivity reactions in many of the systems of the body have been described;⁸ however, the finding of acute ulcerative colitis and cystitis as part of a hypersensitivity reaction penicillin is rare.

Emphasis has been made that the indiscriminate use of the various chemotherapeutic agents and antibiotics in trivial infections might lead to the development of a sensitivity to these valuable agents by the patient and that when a indication occurs for their use, the various hypersensitivity reactions including the mild and the rare serious reactions might develop, and exclude their use.⁹ Emphasis has also been made that in the use of any of these agents the patient should be quizzed as to whether any of the agents have been previously used and if any type of reaction occurred following their use.⁹ To illustrate the above, the following case is herewith presented:

CASE REPORT

Mrs. R. M. M., a 42-year-old housewife was admitted to Emory University Hospital about 7:00 p.m., April 13, 1952.

Read before the Section on Internal Medicine, 103rd Annual Session of the Medical Association of Georgia, Savannah, May 13, 1953.

From the Department of Medicine, Emory University Hospital.

Author's Note: Author wishes to express appreciation to Dr. Abner Golden, Department of Pathology, Emory University Hospital, who interpreted and gave the description of the biopsies of the rectosigmoid and bladder.

About two hours previously, she had received an intramuscular injection of Sharcillin because of an infected splinter wound under the nail of the right middle finger. A few minutes after the injection, she began to feel very nauseated, and red, green, and black spots were visualized, with a stinging sensation all over the outside of her body and burning like fire on the inside. She felt she would black out, that her throat was closing and that she was unable to breathe. At this time, she lost consciousness. According to her referring doctor, she was unconscious, deeply cyanotic and as though her respirations were obstructed from laryngeal spasm. Adrenalin 1 c.c. 1-1000 was administered intramuscularly and the laryngeal spasm cleared. Her color changed from blue to a dusky red, and she became semi-conscious. Peripheral pulsations were not palpable and the blood pressure was unobtainable. About 30 minutes later the patient began to experience "awful" generalized contractions in the abdomen and a feeling as though the bladder was distended, with an urgent desire to urinate.

Intermittently for the past 10 years the patient has had attacks of urticaria and symptoms of vasomotor rhinitis.

For several years the patient had received penicillin for colds during the winter months. In December, 1951, two intramuscular injections of penicillin were administered for a cold. Following each injection within a matter of minutes, the patient felt a stinging sensation over the entire body and the skin turned red. These symptoms lasted only 10 to 15 minutes.

The past history and system review was entirely negative except for the occurrences of anxiety reactions with hyper-ventilation syndrome during the past 10 years.

Physical Examination: Temperature 98°F (rectal). Pulse unobtainable—cardiac rate, 94. Blood pressure o/o. Respiration 40.

The patient, a moderately obese white female, was conscious, extremely restless, breathing rapidly and deeply with frequent sighing respirations. She complained of nausea, lower abdominal cramping pains, vomited frequently, and constantly requested the bed pan for urination and bowel movement. The skin was warm, moist, and dusky red color. The peripheral arterial pulsations were not palpable. The veins were collapsed. The heart sounds were distant and almost embryonal in character. The lungs were clear. The abdomen was relaxed and non-tender. Peristalsis was hyperactive. Pelvic and rectal were not remarkable except for retroverted, slightly

enlarged, and boggy uterus. The neurological examination was physiological.

Nasal O₂, cortisone 200 mgm. intramuscularly were administered immediately, and a venecotomy was performed. Polyethylene tubing was threaded into the vein and a 1000 c.c. of 5 per cent glucose in distilled water with 8 mgm. of Levophed (4 mgm. Levophed base) infusion was begun. Seven hundred fifty c.c. of this solution was administered within 45 minutes without change in blood pressure, or improvement in peripheral arterial pulsations, and because of lack of response, it was discontinued. Five mgm. of neosynephrine intramuscularly and three mgm. intravenously were given. There was marked cardiac slowing after the intravenous administration but this was only momentary and soon a perceptible pulse of 92 per minute and a blood pressure reading of 90/84 were obtained. An infusion of 1000 c.c. of 5 per cent glucose with 20 mgm. neo-synephrine was begun and administered by rapid drip. Because of increasing abdominal pains, and frequent loose watery bowel movements, the patient was given morphine grs. $\frac{1}{4}$ and atropine grs. $\frac{1}{150}$. Four hours after admission, the respirations had slowed to 20 per minute, blood pressure had gradually risen to 120/100 and the pulse was full and at a rate of 120. The infusion rate of the neo-synephrine was slowed and 1 hour later the B. P. was 104/80 and pulse rate of 100. During this period of time the color of skin gradually faded from the dusky red appearance to that seen in a normal brunette. Alternating infusion of the neo-synephrine solution and 5 per cent glucose in distilled water was continued for approximately 24 more hours. During this period the blood pressure, pulse, and respiration remained stable in a normal range.

On admission, the hematocrit was 67, hemoglobin 20 gm. per cent, red blood count 6.56 million per cu. mm., and the white blood count was 46,000 per cu. mm. with 97 per cent segs. These values gradually fell and 36 hours later the hematocrit was 44, hemoglobin 13.4 gms. per cent, red blood count 4.42 million per cu. mm. Two and a half days after admission the white blood count was 15,700 per cu. mm. with 84 per cent segs., 1 per cent eosin., 14 per cent lymphs. and 1 per cent monos.

The patient had nausea and vomiting only during the first 24 hours. The vomitus at first was mucoid streaked with blood and then became a brownish color which was guaiac positive.

The patient continued to have lower abdominal cramps and frequent loose watery movements. The initial stools were watery reddish color (patient had eaten beets for lunch) but guaiac test on two stools during the first four hours of admission were negative and trace. The lower abdominal cramps increased in severity, and frequency of stools increased. Twenty-four hours after admission the stools became watery and mucoid with streaks of blood.

Two and a half days after admission, the stools were bloody mucoid, frequent in number and on one occasion a mucosal cast was noted. Abdominal pains were more intense, and prior and during bowel movements intense cramping was experienced in the sacral and rectal area. The temperature had risen to 101°F and the patient felt ill and uncomfortable. Sigmoidoscopic examination revealed large irregular superficial ulcerations covered with a greyish exudate, and these were present throughout the lower sigmoid, but to a greater extent in the rectosigmoid and rectal areas. With swabbing the areas, denuded, raw "flea bitten," bleeding areas appeared. The intervening mucosa appeared thickened, easily traumatized, and edematous. Cultures were obtained and these were negative for pathogens, and motile amoeba histolytica were not found.

Biopsy of ulceration on the anterior wall of the rectosigmoid was obtained and the description as follows: The specimen shows a fragment of mucosa showing a very striking acute ulceration associated with massive polymorphonuclear leukocyte infiltration (Fig. 1). The process appears to involve the entire mucosa and lamina propria. There is also some acute inflammatory cell infiltration in the submucosa. The most striking changes seen in this area consist of an acute degeneration of small arterioles. Some of the vessel walls are completely necrotic and these vessels contain dense thrombi. The immediately surrounding connective tissue is heavily infiltrated by polymorphonuclear leukocytes. Other vessels show early changes consisting of focal fibrinoid de-

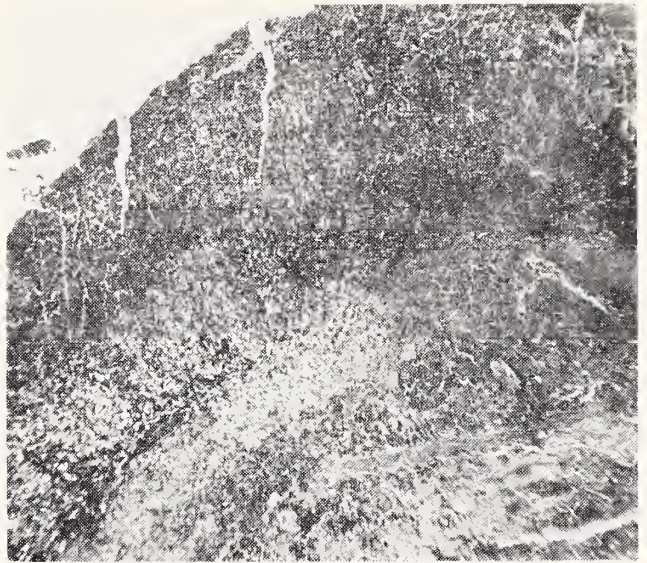


Figure 1. Photomicrograph (low power) of the biopsy of the rectosigmoid mucosa which shows acute ulceration of the mucosa with massive polymorphonuclear leukocyte infiltration.

generation of portions of the arteriolar wall (Fig. 2). There is some inflammatory response in these vessels.

Five and a half days after admission, stools became formed and only a slight amount of blood and mucus was present. Abdominal pains, rectal tenesmus, and sacral pain were abating. On April 21, seven and one-half days after admission, the mucosa of the sigmoid appeared normal, and by April 25, eleven and one-half days after admission, the lesions of the rectum had healed and the bowel movements had been normal without mucus or blood for three days. The temperature returned to normal on April 21, seven and one-half days after admission.

On April 17, the patient was begun on sulfasuxidine gms. 1.5 q4h which was continued until the a.m. of April 22. Atropine, banthine, phenobarbital, paregoric, and milk of bismuth were also utilized.

Even though the patient had a constant desire to urinate, a urine specimen had to be obtained by catheterization about three hours after admission. This urine specimen of 400 c.c. volume had a pH of 5, specific gravity 1.020, 1 plus reaction to Robert's reagent, 3 plus reaction for reducing substances. 2-5 white blood cell, many coarsely granular cast and an occasional white blood cell cast per high power field. For the next 48 hours catheterizations were required intermittently.

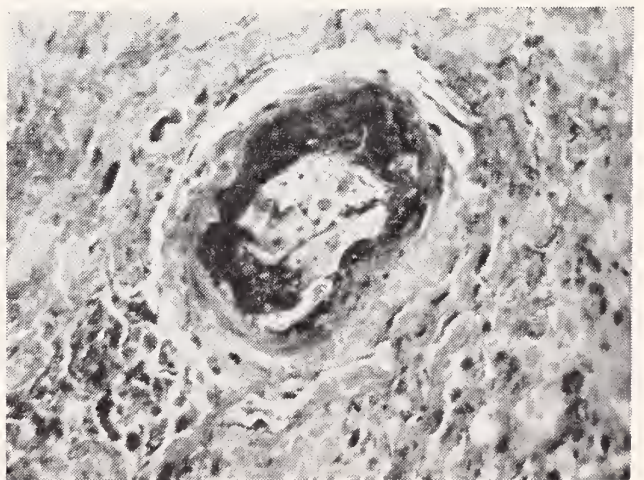


Figure 2. Photomicrograph (X 475) of an arteriole of the submucosa of the rectosigmoid which demonstrates fibrinoid degeneration of the arteriolar wall, thrombus formation, and inflammatory response.

A urine specimen on the a.m. of April 15, had a specific gravity of 1.002, albumen and sugar negative, and only an occasional white blood was present. However, urgency, constant desire to urinate, pain in suprapubic area, pain with urination, tenesmus, and difficulty in voiding continued and on the morning of April 16, innumerable white blood cells and a moderate number of red blood cells were found in a catheterized urine specimen. Urine cultures were obtained but were lost. Aureomycin 250 mgm. q6h was begun and continued for six days. By April 19, the urine had only an occasional white blood and red blood cell.

The urinary output for the first 12 hours of hospitalization was 790 c.c. and the total for first 24 hours was 1850 c.c. The fluid intake approximated 4500 c.c. During the next 24 hours the urine output was 3150 c.c. On the morning of April 15, 36 hours after admission, the NPN was 34 mgm. per cent, CO_2 28.5 mEq./L., chlorides 102 mEq./L., sodium 138 mEq./L., and potassium 4.5 mEq./L.

On April 18, the patient was cystoscoped by Dr. Earl Floyd and his findings were: The bladder was distended with about 300 c.c. slightly turbid urine. A 24 cystoscope was passed. The bladder mucosa was edematous with small superficial ulcerations covering the trigone. The entire bladder mucosa elsewhere showed small petechial hemorrhages which had not broken down. Both ureteral orifices appeared edematous. Biopsy was taken from the trigone area and the description is as follows: The bladder mucosa showed marked congestion, polymorphonuclear leukocytic infiltration and a suggestion of slight ulceration. One or two vessels showed slight changes similar to those described in vessels of the rectosigmoid biopsy.

A Foley catheter was left in bladder and it remained in the bladder until the last cystoscopic on April 22. The bladder mucosa at this time had two small hemorrhagic areas on the left lateral wall and one on the left base just lateral and anterior to the left ureteral orifice. The latter measured 1x1 cm.; was dark in appearance and elevated, but no ulcerations were present.

The patient was discharged from the hospital on April 26, twelve and one-half days after admission. She was free of symptoms. The bowel movements and micturition were normal. She has remained in good health except for occurrences of vasomotor rhinitis and episodes of hyperventilation.

Comment

There is direct clinical evidence that the anaphylactic shock and subsequent course presented by this patient was due to a hypersensitivity reaction to procaine penicillin. The pathological changes demonstrated in the arterioles of the submucosa of the rectosigmoid and bladder of this patient are compatible with the pathological changes due to anaphylactic hypersensitivity produced experimentally by Rich and his co-workers with other agents.^{11 12} Intradermal skin testing with penicillin was not done because it was feared that untoward anaphylactic reaction might occur and such reaction has been reported by Mayer.⁷

Cortisone was administered initially intramuscularly because it has been shown by Rich and his co-workers that cortisone as well as the adrenocorticotrophic hormone will prevent the vascular lesions of anaphylactic hypersensitivity.^{13 14} Apparently the pathological changes in the arterioles of the bladder and colon were initiated almost immediately as noted by the incessant desire to urinate and the frequent loose watery bowel movements which began soon after the patient regained consciousness. In retrospect, cortisone should have been continued, but it was not resumed after ulcerative colitis and cystitis were evident because it was obvious clinically, that the patient would make an uneventful recovery.

To quote Rich,¹¹ "These observations indicate that the continued administration of a sulfonamide or

of foreign serum after symptoms of hypersensitivity have appeared . . . carries the danger of producing vascular damage of the periarteritis type." This is directly applicable to this patient for on two previous occasions following penicillin injection, she had experienced hypersensitivity reactions as manifested by a stinging, burning sensation over the entire body and a redness of the skin.

Previous administration of penicillin to this patient apparently had been for trivial infections such as colds, and as a result hypersensitivity developed, and on subsequent administration anaphylactic hypersensitivity with almost disastrous reaction occurred. Its use in the future for an indicated infection, if it occurs in this patient, is now excluded. Trivial infections will subside as they did prior to the advent of the chemotherapeutic and antibiotic agents and these agents should be reserved for use in those infections where they are indicated and where they will definitely alter the course of the infection.

Conclusions

1. Anaphylactic shock, acute ulcerative cystitis, and acute ulcerative colitis as a manifestation of an anaphylactic hypersensitivity reaction to procaine penicillin, occurring in a patient with recovery, has been presented.

2. The indiscriminate use of antibiotics in trivial infections should be avoided because of the possibility of the development of a sensitivity to the agent.

3. All patients should be quizzed as to previous antibiotic administrations, and whether hypersensitivity reactions occurred at that time for, as has been shown in this case presentation, anaphylactic hypersensitivity reactions may occur with subsequent doses.

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DISCUSSION

DR. J. H. HILSMAN (Atlanta): The etiology of acute ulcerative colitis, and probably also the acute ulcerative cystitis in this case report, is unknown. The basic importance of the case report by Dr. Whipple, I think, lies in its contribution to our attempts to understand this etiology. Up to a few years ago it was felt that the etiology was due to some specific agent or group of agents, but this has never been firmly established or fully accepted. In 1930 Murray emphasized the role of the psyche and, since then, there have been many reports on the response of the colonic mucosa to various emotional stimuli. Such responses, however, are quite variable and seem to depend to some extent upon which division of the autonomic nervous system is predominant, to what strength the stimulus has, and to what extent the individual can respond. Also some people feel these emotional states are as much result as cause.

Therefore, the conviction is growing that probably hypersensitivity does play a part in the etiology of ulcerative colitis. This feeling is substantiated by the fact that certain common pathological changes are noted not only in such cases as just presented, but in others made sensitive to sulfanamides and other so-called non-toxic agents, in known cases of polyarteritis nodosa, rheumatic fever, serum sickness, etc., as well as in experimental animals made hypersensitive by horse serum injections as reported some years ago by Rich & Gregory. These basic pathological findings are more or less common to the collagen-vascular group of

diseases and are characterized by fibrinoid degeneration and necrotizing angiitis. Fibrinoid degeneration is probably a non-specific reaction by connective tissue to injury. But vascular changes as represented by the necrotizing angiitis is probably more basic, although Zeek in a recent article in the *New England Journal of Medicine* feels such changes do not represent a pathological entity, as there are too many known different causes and too many different clinical end results. And too, we know that certain lesions with such necrotizing angiitis are benefited by cortisone or ACTH, whereas others are not.

Therefore hypersensitivity is probably not the common denominator in all cases of ulcerative colitis. The role of shock here is difficult to evaluate, but Selye has emphasized the point that shock with its anoxia is a powerful stressor agent to initiate the alarm-reaction, plus the point that the gastrointestinal tract is particularly susceptible to such reactions. Selye has also reported with his work on DOCA that individuals with one of these collagen-vascular group of diseases may possess an abnormal adaptive mechanism through their adrenal cortex to make such patients even more susceptible to stress agents, antigens, emotions, etc. This is not proven, though, by any means.

Therefore, I think, Dr. Whipple's paper has further emphasized the fact that probably several factors are causative in the development of acute ulcerative colitis. Some of these factors are understood and some are not; some are direct by being definitely etiological and others are indirect by governing the patient's response.

TRILENE *for* OBSTETRICAL ANALGESIA

During the past 10 years there have occurred at least two new techniques for pain relief during labor and delivery: "natural childbirth" and conduction (nerve block) anesthesia. The idea of using "Trilene" for obstetrical analgesia and anesthesia was also "something new." The various reactions to "something new" may be enthusiasm, skepticism, or rejection; skepticism was the original attitude of the author.

It is generally agreed that no known method of obstetrical analgesia will give 100 per cent pain relief to every woman in labor with absolute safety for mother and child. The drug used should not interfere with the normal course of labor nor should

SEYMOUR P. WEINBERG, M.D., Atlanta

it add to the hazards of childbirth by depressing fetal respirations. The results in large clinics, e.g., the Yale group with 1,000 consecutive "natural childbirth" patients, have not borne out some of the more extravagant claims for the method (less than 20 per cent completely successful). Conduction anesthesia is recognized as having a limited field for its application. Therefore, it was decided that a trial using "Trilene" was in order, with the idea of learning more about this drug, either alone or as an adjunct, during labor and delivery.

"Trilene" is the registered trademark of Ayerst, McKenna and Harrison L.T.D. for trichlorethylene ($\text{CCL}_2:\text{CHCl}$). It is a colorless liquid with a slightly pungent, fruity odor; 132.5 molecular weight; 87°C boiling point. The product is colored with

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waxoline blue to distinguish it from chloroform. The preparation is pure and suitable for inhalation use. It is non-inflammable and non-explosive. No injury to the liver or kidney has been found after long-continued exposure to trichlorethylene vapor. The compound is excreted mainly from the lungs in expired air, a small amount being excreted through the kidneys as trichloroacetic acid. Neurotoxic decomposition products are formed if the agent is exposed to air and sunlight for more than three or four days. For safety, any unused material in the inhaler should be discarded at the end of each day.

Trilene can be administered by the patient or by an untrained assistant. A special hand mask inhaler is used which is small in size and cost. Premedication is not necessary since Trilene does not stimulate the production of salivary secretions. The potency of the vapor can be regulated and no excitement stage occurs during induction. The drug action is of short duration and may be administered intermittently or constantly. The analgesia attained without loss of consciousness is said to be more profound and prolonged than that produced by other available agents.

Material and Methods

This series of 133 cases is from patients admitted to the Saint Joseph Infirmary, Atlanta, Georgia, both private and service. There was no attempt made to force the usage of this drug upon the patient and it was discontinued if the patient objected. It is probably unfortunate that no one observer was used as the judge of the objective findings, but this situation was found to be impractical in this hospital. The administration of the drug throughout the course of labor was by self-administration, administration by an assistant (usually a nurse) or a combination of the two.

CHART I

Self administered throughout.....	37	28%
Assisted administration throughout.....	25	18%
Combination	71	54%

A majority of the patients to whom Trilene was administered by an assistant were patients who received the drug for delivery only.

In many of the cases the Trilene was self-administered during the first stage of labor and assisted in the delivery room which accounts for the large number of patients recorded as "combination" administration.

The duration of Trilene inhalation in this group of patients varied according to the following chart:

CHART II

No. of Patients	38	28	19	18	9	3	7	5	2	3	1
Time in Hours	1	2	3	4	5	6	7	8	10	12	15

The shortest period of time was in the case of a patient admitted directly to the delivery room. The longest recorded duration of administration was 15 hours.

An analysis of the age and parity of these patients revealed nothing unusual. There was the usual spread in the age group and parity.

CHART III

Age in Years						
(U* — Under)	U20	U25	U30	U35	U40	U45
No. of Pt.	25	47	36	16	8	1

CHART IV

Parity	0	1	2	3	4	5	6
No. of Pt.	37	39	31	11	9	4	2

The explanation of the incidence of multiparity in 72 per cent of the cases which may be considered high, lies in the fact that there is a generally higher incidence of multigravidas among the patients attending the clinic and a significant number of these patients are included in this series.

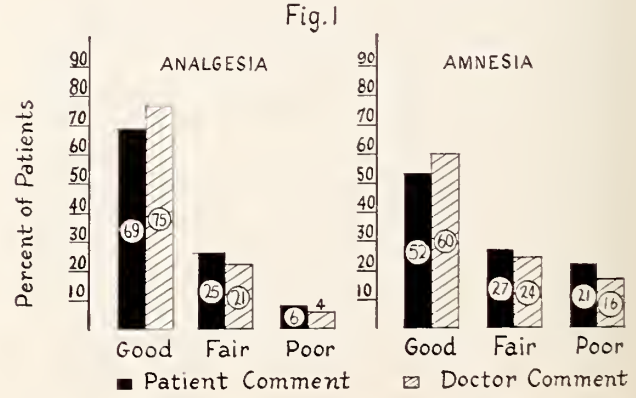
It should be recognized that only a small number of these patients went through their labor and delivery using only Trilene. Novacaine, either as infiltration or pudendal block, was used in many cases for delivery. This was more often true in those cases which had episiotomies. It was felt by some of the physicians, as more experience was gained in the management of these patients, that the sedative effect of a drug, such as demerol, in small doses, increased the effectiveness of the Trilene administration. The average dose of Demerol in these patients was 75 mgm. with a range of 50 - 200 mg.

CHART V

Drugs Administered	Number of Patients	
Trilene only	31	24%
Trilene and Novocaine	77	58%
Trilene and Demerol	19	14%
Trilene and Demerol and Novocaine	6	4%

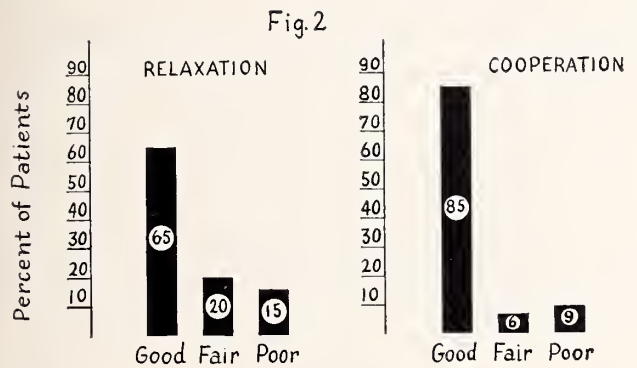
Effect on Mother

The attempt to evaluate the effects of this drug on the mother was approached from two viewpoints, that of the patient and that of the attending physician. The physician was asked to record his impressions of the analgesic and amnesic effects on the patients and the degree of relaxation and cooperation of the patients. The patient was questioned during the post-partum period about her reaction concerning analgesia and amnesia. The reactions were graded as good, fair or poor. Figure 1 indicates the results obtained and interpreted in terms of the percentage of patients.



It will be noted that the degree of analgesia and amnesia tended to be judged "good" in more cases by the observer than by the patient. It will also be noted that more patients were satisfied with the degree of analgesia than with the degree of amnesia. It was not anticipated that any amnesia would be obtained from the use of Trilene. However, it soon became apparent that the patients were obtaining a definite but variable degree of amnesia. This varied with the constancy of administration and when the periods of inhalation were at more protracted intervals, the patient tended to recover between inhalations from the amnesic state.

Figure 2 is a record of the observer's impression of the patient's relaxation and cooperation:



During the course of the observations it was noted that some of the unpleasant effects of other forms of sedation were not noted. It was very pleasant to encounter no "wild" patients. Most of the patients were quiet and required no restraining. While many of the patients were able to relax well, some cooperated but were unable to relax. A tendency was noted for the patient to remove the inhaler and forget to return it to her face with the next contraction unless assisted. This was interpreted as evidence that sufficient analgesia or amnesia remained from the previous inhalations.

At the same time it should be noted that side effects were occasionally encountered. Most of these reactions as noted by the observer and experienced by the patient were of mild degree.

CHART VI

Side Reaction	Number of Patients
Restlessness	31
Dizzy	20
Nausea	8
Vomiting	12

It should be recognized that any one patient may have experienced one or more of the effects. A total of 48 patients (36 per cent of the total) experienced one or more of the side effects, and are included regardless of the degree present, e.g., if the record showed only minimal restlessness, this was still included in the reaction group.

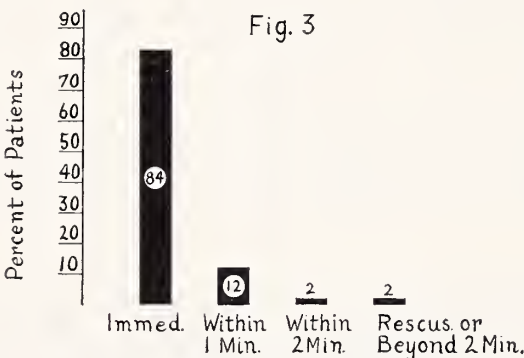
Included among the effects of the drug, the observers attempted to evaluate the effect of the drug upon the course of labor. Most of the observers

stated that no effect on the uterine contractions was noted, however, a slight slowing of the course of labor was recorded in 15 patients or 11 per cent of the total series.

Of course, one of the most important measures of the success of a new procedure is the willingness of the subject to use the same procedure in the future, should the occasion arise. In this series, 81 per cent of the women who were questioned stated that they wished to have Trilene during a future labor and delivery. This is a gratifying number when one considers that very few of these patients had been oriented to the new method and that we physicians have not yet acquired all the technical know-how of the administration of this new drug.

Effects on the Fetus

To infer that obstetrical analgesia and anesthesia is responsible for all the respiratory distress of the newborn infant is incorrect. Patients receiving no medication may be delivered of newborn infants with depressed respirations. However, no other factor lends itself as readily toward measuring the safety index and value of the obstetrical analgesic drug as will the rapidity of onset of spontaneous respirations by the newborn. The records of the onset of fetal respirations are shown in Figure 3.



That only three newborn (2 per cent) required resuscitation is believed to be indicative of a good result. In one of these cases the patient had received 200 mgm. of demerol and it is felt that at least part of the responsibility is removed from Trilene because of this. Another was a breech delivery with moderate difficulty in delivery of the head and the patient had received 100 mgm. demerol I V-45 minutes before delivery. The third case was merely delayed beyond two minutes and was given oxygen after bulb aspiration. When 84 per cent of newborn infants breathe immediately and an additional 12 per cent within one minute, it will be generally acknowledged that the attending physician is subjected to less stress and strain. At the same time, it means that one should be prepared to maintain a clear airway for the baby and so prevent aspiration in the newborn with its first respiratory efforts.

This series of cases included some of the usual complications of pregnancy referable to either the mother or the child.

CHART VII

Complications Encountered

Hypertension	1
Marked anemia	1
Healed Tuberculosis	1
RH Negative	1
Low-lying placenta	1
Breech presentation	3
Cord around neck	2
Prematurity	5
Stillborn	2
Post partum Hemorrhage-Cervical Laceration	1

The two cases of the birth of stillborn fetuses were cases in which no fetal heart tones were heard on admission to the hospital. The premature infants all breathed spontaneously, two immediately and three within one minute. The patient with the post-partum hemorrhage from a cervical laceration had been receiving intravenous pitocin for uterine inertia. It was not the opinion of the observer that the use of Trilene contributed to the complication as it developed. In fact, in none of the cases was it felt that the use of Trilene during labor and/or delivery contributed toward any of the complications encountered, but rather was an aid to some of the situations.

There were other obstetrical complications arising during this period which were managed by cesarian section. They are not reported as part of this series, but have been accumulated as another study.

Comment

We are cognizant of the fact that 133 cases does not constitute a large series, probably not even a statistically significant group of cases. It was our feeling that we wished to investigate this drug to learn for ourselves whether Trilene did offer any new advantages, for the mother, for the child, and thereby for the attending physician.

Careful analysis of the record of each of these 133 patients served to indicate that the patient should be treated as an individual and not as a group. What might be excellent for one might be a failure for another. It appeared that the patient's psychological and physical status must be evaluated, her past experiences with labor considered, and the effects of the previous drug administration assessed. It appeared that those patients in whom the problem of analgesia and anesthesia during labor and delivery was made a part of the prenatal care adjusted more readily to this new technique. A co-operative, intelligent patient enhanced the value of this drug by the ease of administration. Of course, a certain amount of time must be spent with the uninformed patient demonstrating the method of self-administration. At the same time, a certain amount of careful observation by either the physician or the nursing staff is necessary to assure that the patient is performing her part properly.

The objective observations and the subjective comments indicated a good amount of analgesia was obtained by the use of Trilene. It was a surprise to

learn the degree of amnesia these patients obtained from this drug without any manifestation of excitation. It is probable that with continued experience and the combination of this drug with a mild sedative, future use may yield even better results. The results with fetal respiration obtained in this series compare favorably with those reported in other series with other commonly used techniques. No complications were encountered which contra-indicated the use of Trilene. There was no increased evidence of post-partum hemorrhage and the recovery period was one of drowsy euphoria.

Conclusions

- (1) Trilene will produce a good degree of satisfactory analgesia-amnesia in the average laboring woman.
- (2) Side effects, mostly of a mild degree, were quoted in 36 per cent of the cases.
- (3) Progress of labor is not materially interfered with.
- (4) Respiratory depression of the fetus is less striking than with other commonly used agents.
- (5) No untoward complications were noted.
- (6) Eighty-one per cent of the patients desire to have Trilene with their next labor.

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**For New MAG Committee
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PSITTACOSIS 111

GEORGIA

Parakeets have been enjoying a wide-spread and increasing popularity as household pets since 1951, when changes in the Interstate Quarantine Regulations removed all federal restrictions on shipments of psittacine birds from psittacosis-free areas in the United States.

No epidemics of psittacosis, the virus infection transmitted to man by these birds, have since been reported, and the public has assumed that this disease will rarely be encountered, provided the birds have not been brought illegally into this country.

Sporadic cases and small outbreaks are being reported throughout the United States, however, and it is probable that the psittacine origin of many cases of "virus pneumonia" or "primary atypical pneumonia of unknown etiology" remains unsuspected.

The purpose of this report is to call to the attention of the physicians of our state that cases of psittacosis are being seen in Georgia. They are urged to report instances of this infection, so that a more accurate appraisal of its incidence, and thereby, its importance or lack of importance as a public health problem, can be made.

The problem is not limited to parakeets, since a wide variety of birds, including parrots, canaries, pigeons, doves, rice birds, finches, sparrows, pheasants, gulls, turkeys, chickens, and ducks are susceptible to infection with psittacosis and related viruses.

In man the infections appear more severe when acquired from members of the parrot family. The term "psittacosis" has been used to designate those infections of man and birds originating in the parrot family. The latter includes, besides parrots and parakeets, Amazons, Mexican double heads, African grays, cockatoos, lovebirds, lorries, and lorikeets.

The term "ornithosis" is often used to refer to avian infections of non-psittacine origin. At times, however, both terms have been used interchangeably to designate the entire group of avian viral infection.

REPORT OF CASES

In the last week of April 1953, in cities 170 miles apart, Mrs. W. C. (age 80, Atlanta) and her daughter Mrs. M. D. (age 43, Albany) had the onset of a remarkably similar illness. Within three days both began having high fever (up to 104°-105°), chilliness to frank shaking chills, headache, epistaxis, malaise, anorexia, and aches and pains. Both subsequently developed a well-defined area of pneumonic consolidation on physical and roentgen examination (See Fig. 1 and 2), but without cough, sputum, dyspnea, tachypnea, or chest discomfort. In addition, Mrs. W. C. complained of considerable nausea and mild diarrhea; her daughter, of photophobia on the right.

The daughter became acutely ill shortly before coming to



Fig. 1. Mrs. W. C.: Pneumonia, right lower lobe.

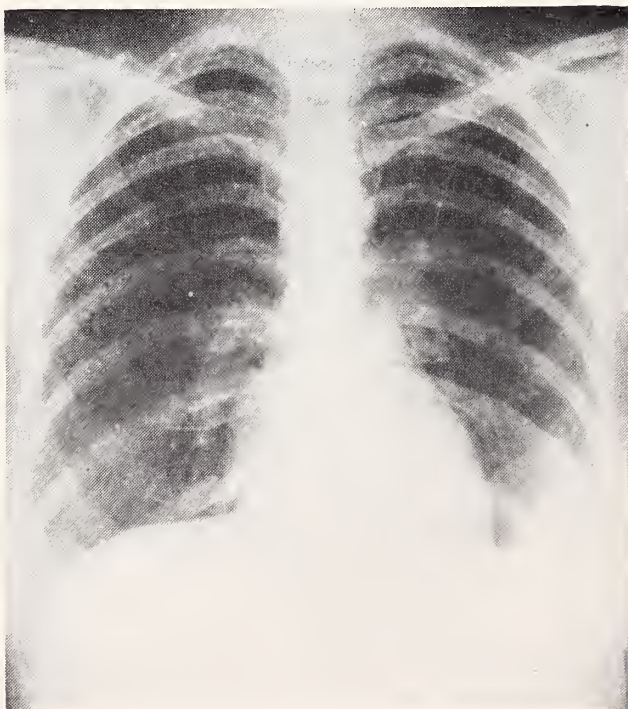


Fig. 2. Mrs. M. D. Pneumonia, left lower lobe.

From the Buckhead Clinic, Atlanta, Georgia

Atlanta to visit her mother who just had been hospitalized. Subsequent questioning revealed that the mother had visited this daughter in Albany about one month previously for a period of two weeks, and that the daughter had acquired two baby parakeets during her visit. The parakeets, which were purchased locally in Albany, did not become ill.

Both patients responded promptly and well to terramycin in the usual dosage. Two weeks after discharge from the hospital both had relapses, with a return of chills and fever, malaise, et cetera. This responded to procaine penicillin (600,000 units intramuscularly daily), but more gradually and less dramatically than with terramycin. (The relapses were not treated again with terramycin because Mrs. W. C. developed a severe post-antibiotic diarrhea, which finally responded to neomycin.)

The convalescence of Mrs. W. C. has been prolonged, with continued weakness, malaise, and anorexia gradually improving. The viral pneumonia has been slow to resolve on physical and roentgen examination, but except for an occasional mild non-productive cough and some chest fullness, which began only after the patient became afebrile, respiratory symptoms have continued absent. (The convalescence of Mrs. M. D., whom I have not seen since her return to Albany, is also said to have been prolonged.)

The husband of Mrs. M. D. also developed fever, malaise, and headache, within two days after she became ill. He was treated with penicillin and terramycin by their family physician in Albany, with a rapid recovery. He never did appear very ill. In contrast, the elderly Mrs. W. C. had been severely ill, and Mrs. M. D. moderately so.

Complement-fixation tests for psittacosis were negative on control sera obtained from these patients during the first week of illness. At the end of three weeks, Mrs. W. C. had a positive test, with a titer of 1:64-1:128. Mrs. M. D.'s was positive at 1:4, dilution, and M. D.'s serum was still negative. Follow-up examinations will be obtained.

The two suspected parakeets from the Albany aviary were sent by the Department of Public Health to the Virus Laboratory in Montgomery, Alabama, for virus identification. The psittacosis virus was isolated from the spleen and liver of one of these parakeets.⁴

The aviary in question began breeding birds four years ago. The original stock consisted of two pairs of birds which were obtained from a pet shop in Miami, Florida. No additional birds have been purchased. The aviary's sale of parakeets, which now amounts to about 300 birds per year, has been discontinued during the present investigation.

Discussion

The clinical features of psittacosis are adequately reviewed in the standard medical textbooks and are well illustrated by the above cases.

A few points should be emphasized, however:

1. The infected birds may not appear ill.
2. The clinical course most often stimulates atypical pneumonia, influenza, and typhoid fever.
3. There may be well-defined signs of pneumonic consolidation on percussion, auscultation, and roentgen examination, with little or no symptoms of pneumonia (dyspnea, tachypnea, cough, hemoptysis, or chest discomfort).
4. The radiographic appearance of the pneumonia is non-characteristic.
5. Epistaxis is fairly common.
6. The disease responds well to the broad-spectrum antibiotics (aureomycin, terramycin, and, perhaps less well, to penicillin and chloromycetin).
7. Despite adequate therapy, relapses may occur. Also, as with any other viral pneumonia, convalescence may be prolonged.
8. The only widely available procedure for diagnosis is the demonstration of antibodies in the serum of patients during convalescence by means of the

complement-fixation test. Specimens of blood should be sent to the Department of Public Health. (The examination is performed by the Communicable Disease Center of the United States Public Health Service in Chamblee, Georgia). The tests do not usually become positive until during or after the second week of illness, and the response may be considerably delayed or modified by antibiotic therapy.

Approximately 40 clinical infections are recognized annually in the United States,⁵ but in 1952 this number rose to 147.⁴

Only six cases of psittacosis have been reported to the Department of Public Health in Georgia from 1930 through 1952, and only one since 1941.

In April of this year, Dr. A. Park McGinty and Dr. Marvin Mitchell of Atlanta, obtained a positive complement-fixation test (titer 1:32) in a man who had a febrile illness, with muscle aches, but without evidence of pneumonia. The patient had raised chickens and pigeons as a hobby for several years, and also had a pet parrot.

This is somewhat difficult to evaluate since Meyer⁵ has pointed out that individuals constantly exposed to psittacosis virus, such as aviary owners, pet shop employees, pigeon breeders, as a rule show complement fixing antibodies in their sera in titers varying from 1:8 to 1:32.

Two proven cases of psittacosis in one household were reported to the Department of Public Health from Albany during the month of June by Dr. Glenn Seymour. The diagnosis was confirmed by complement-fixation test (titer 1:128) and by isolation of the virus from the infected birds. The parakeets had been obtained from a local aviary via a local seed and feed company. Clinical details are not yet available.

During the month of May three possible cases of psittacosis in one family were also reported from Fort Gaines, Clay County, near Albany. The clinical findings were those of influenza and pneumonitis, with a history of exposure to parakeets recently obtained from Jacksonville, Florida. The results of complement-fixation tests have not yet been reported.

Six months ago, the Department of Public Health removed all regulations concerning the selling and breeding of psittacine birds, and now no routine inspection is made of any of the bird-breeding and selling establishments.⁴

There is at present no simple way of determining whether asymptomatic birds are carrying the infection, so that preventive public health measures are difficult to apply. One practical measure would be to educate bird owners and breeders and the public generally of the uncommon but potential hazard of psittacosis and to instruct them to remind their physicians of this possible source of infection when they come down with "pneumonia" or "influenza."

The Department of Public Health is now investigating the prevalence of psittacosis in the Albany area. When this study is completed, a progress report will be made.

Conclusion

The possibility of an avian source of infection

should be considered in all cases of "atypical pneumonia" or "flu", particularly when they occur at times other than the usual upper respiratory infection season.

Parakeets, parrots, pigeons, and barnyard fowl are commonly implicated members of this group.

Note: Since preparation of this paper two additional cases of psittacosis have been observed in the Atlanta area.⁸

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Ascending

ERECT PHLEBOGRAPHY

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The visualization of the venous channels of the lower extremities for the purpose of evaluating the patency of the deep veins and the status of the valves of these veins has been of considerable value in the management of chronic venous insufficiency. Several methods of phlebography have been reported in the literature. Some of these have been discarded because of the doubtful value of the information obtained from them. The purpose of this paper is to present a brief discussion of phlebography with emphasis upon the ascending erect technique as is used at the present time at this hospital.

Venograms were first done by Berberick and Hirsch² in 1923 and were popularized after the publication of Dougherty and Homans.³ Interest waned for a few years, but was renewed in the last decade with publications by Mark,⁹ Mahorner,³ Felder,⁴ and others.

The earlier techniques usually involved injecting the contrast media into a vein of the foot or ankle with the patient in the prone or supine position on

the X-ray table. Others used the Trendelenburg position with a tourniquet at the groin to delay emptying of the venous system. Mahorner⁸ added the refinement of a tourniquet at the ankle in order to direct the contrast material into the deep veins. In general these methods failed to give good visualization of the deep venous system because of incomplete filling. Moreover, the presence or absence of competent valves in the deep and communicating veins becomes a matter of conjecture since the antigravity or functional mechanism of the valves is not tested in either the horizontal or Trendelenburg positions.

Retrograde phlebography has been advocated by Luke⁷ and Shumacker¹² who inject the dye into the femoral vein at the groin. Bauer¹ surgically exposes the femoral vein at the groin and through a catheter introduced into the distal portion injects the contrast media with the foot of the table lowered. Another method of threading a catheter through the short saphenous vein into the deep system has been described.⁵

Martin and McClery¹⁰ in 1950 described an improved method of ascending phlebography with the patient in the supine position using an ankle tourniquet and a blood pressure cuff on the lower thigh.

At this hospital we have adopted the method of ascending phlebography in the erect position as de-

This paper was awarded second prize in the annual contest sponsored by The Georgia Chapter, American College of Surgeons.

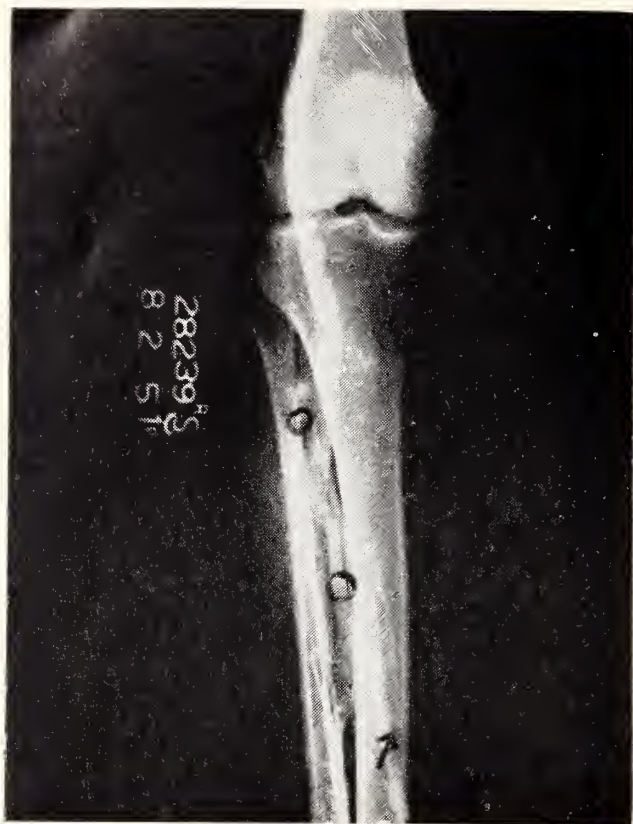


Fig. 1. Case 1. Dense opacification of the deep veins, including anterior and posterior tibial groups and the popliteal vein. These veins are patent, and an adequate number of anatomically intact and functional valves are demonstrated. Two such valves are indicated by circles. Medially, at the arrow, an incompetent communicating vein between the posterior tibial vein and a varicose superficial vein of the great saphenous system is visualized.

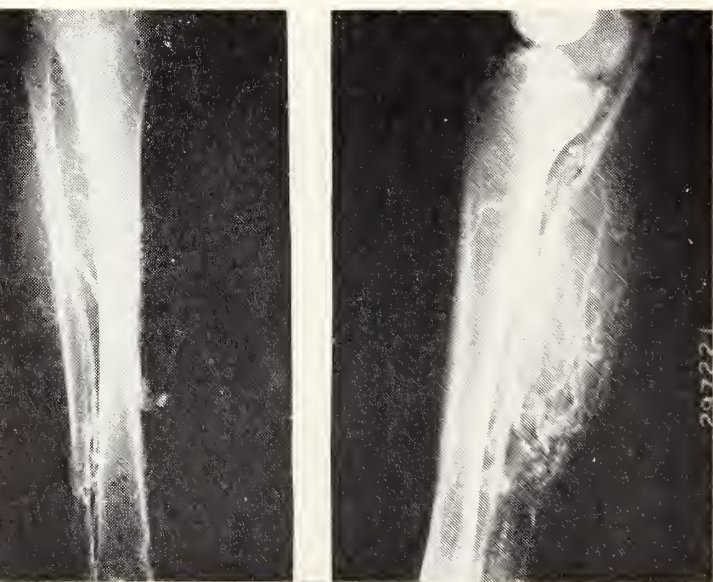


Fig. 2. Case 2. Patent deep veins, which are adequately supplied with functional valves. A large incompetent communicating vein between the superficial and deep systems is visualized medially on the frontal film. This corresponds to the site of a larger chronic ulcer of the leg. Note the early filling of other smaller incompetent perforators and associated varicosities. The lateral radiograph, taken a few moments later, demonstrates the extensive abnormal filling of superficial veins by the radiopaque media. In this projection, the deep veins are seen in close proximity, to the posterior aspects of the bones, following the curves of these structures.

scribed by Scott and Roach¹¹ of Johns Hopkins in 1951, and in the past year the procedure has been performed on 75 patients.

Technique

The patient is placed on the radiographic table which is elevated to an angle of 75 to 80 degrees. The patient stands on the foot rest with the leg to be studied in the mid portion of the table. The leg is internally rotated 25 degrees to minimize superimposition of bony and vascular structures. A tourniquet is placed just above the ankle and tightened sufficiently to obstruct the superficial venous system.

A 20 gauge needle is then inserted into a vein on the dorsum of the foot and is held in place with adhesive tape. The needle is connected by a short piece of rubber or plastic tubing to a syringe containing 25-30 cc. of 35 per cent diodrast. The contrast media is then injected rapidly but not forcibly over a period of 5 to 10 seconds. Films are now taken of the leg and of the lower thigh and if indicated, of the entire thigh. When the volume of the venous bed appears to be increased by the existing pathology, a greater volume of diodrast (30-50 cc.) is used. These films can be taken without haste because, in this position, the contrast media leaves the venous channels rather slowly.

Patients are tested for sensitivity to diodrast by intradermal skin test and further checked by injecting 1 cc. of the contrast media at the beginning of the phlebographic procedure and waiting a few seconds before completing the injection. There have been several instances of transient syncope prior to the injection of diodrast. These are due to a combination of psychic factors related to the various aspects of the procedure. A mild urticaria following the injection was noted in one patient. No other reactions have been encountered.

This method of phlebography provides satisfactory filling of the deep venous system of the leg and demonstrates the presence or absence of competent valves. The abnormal pattern resulting from recanalization of a thrombosed vein is readily detectable. With the tourniquet firmly applied at the ankle, the diodrast is directed from the venous network of the dorsum of the foot into the deep veins of the leg, and no contrast media appears in the superficial veins unless the valves of the perforating veins are incompetent.

CASE REPORTS

The following case reports will illustrate some of the information that can be obtained from this method of phlebography:

Case 1. N. W. Reg. No. 34,035 (Figure 1). This 55-year-old white male farmer had a history of large varicose veins in right leg of several years duration. Examination revealed large dilated, tortuous veins on the medial side of the right lower leg. Clinical tests revealed incompetency of the valves of the superficial system. A phlebogram of the right leg showed incompetency of the valvular structures of the deep veins with incompetency of the valves of one of the communicating veins between the posterior tibial vein and the varices.

This patient was treated with high and low saphenous ligation and stripping with ligation of the perforating veins.

Case 2. J. C. Reg. No. 36,095 (Fig. 2a and b). This 25-year-old white service station attendant had a history of varicose veins for six years. He had a large ulcer over the anterior-medial aspect of the left lower leg which had been

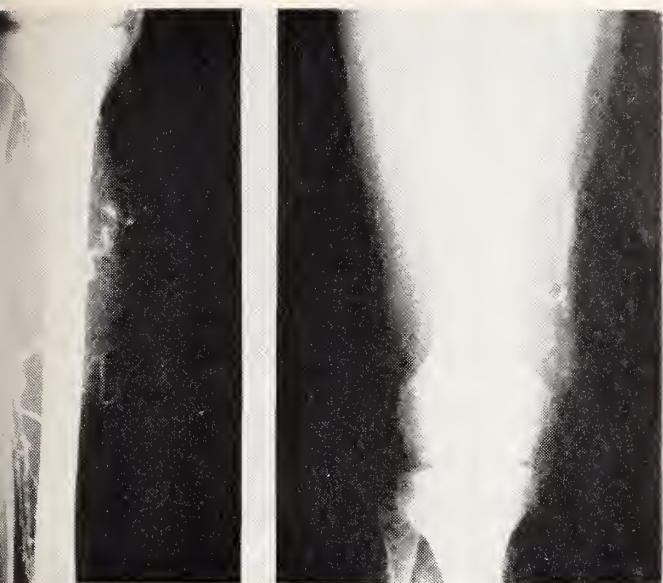


Fig. 3. Case 3. The irregular, web or lace-like appearance of the deep veins best visualized between the osseous structures just below the knee indicates previous thrombosis with subsequent recanalization and destruction of valves. Few deep veins in the legs are patent. Only distally are several valves seen. Abnormal collaterals shunt the blood into the superficial veins. The greater saphenous vein, in which normal valves are demonstrated proximally, transports nearly all of the venous return from the extremity.

present for six months and had failed to heal. There was edema and induration around the ulcer. Clinical tests were confirmed by phlebogram which showed normal deep veins with abnormal filling of the greater and lesser saphenous systems of superficial veins, indicating incompetent communicators. Directly over ulcer on the medial aspect of the lower leg a large incompetent communicating vein is noted.

The patient had high and low saphenous ligations with stripping down to the ankle and ligation of the incompetent perforating veins. The ulceration healed readily without further treatment.

Case 3. J. C. L. Reg. No. 37,938 (Fig. 3). This is a 35-year-old white male who had an acute thrombophlebitis of the left leg in 1945 with secondary pulmonary embolism. A ligation of his superficial femoral vein on the left was done at that time. Since then he has had swelling, ulceration and recurrent bouts of cellulitis of his left lower leg. Phlebogram reveals that the venous circulation is from patent deep veins distally, then through large communicating veins into the greater saphenous system and to a lesser extent into the lesser saphenous system. The deep veins above this show evidence of recanalization with destruction of valves. Several functional valves are seen in the greater saphenous system.

A popliteal ligation was done on this patient and he has had some early improvement. A segment of the popliteal vein showed recanalization of an old thrombus.

Case 4. F. S. Reg. No. 34,386 (Fig. 4). This 35-year-old white male had a history of bilateral acute thrombophlebitis with bilateral superficial femoral vein ligations five and one-half years ago. He has continued to have chronic edema and pain in both legs. His phlebograms bilaterally showed complete absence of deep circulation. All the contrast media is visualized in the superficial veins.

This patient was fitted with full length elastic stockings and treated conservatively. It is obvious from the radiographic findings that ligation of the popliteal or other deep veins in this patient would be a useless procedure. This information could not be determined by clinical tests alone.

Case 5. J. H. B. Reg. No. 33,587 (Figure 5). This 32-year-old white male had bilateral superficial femoral vein ligations 7 years ago. This phlebogram shows evidence of recanalization following thrombosis with complete absence of the valves of the deep veins and poor visualization of the

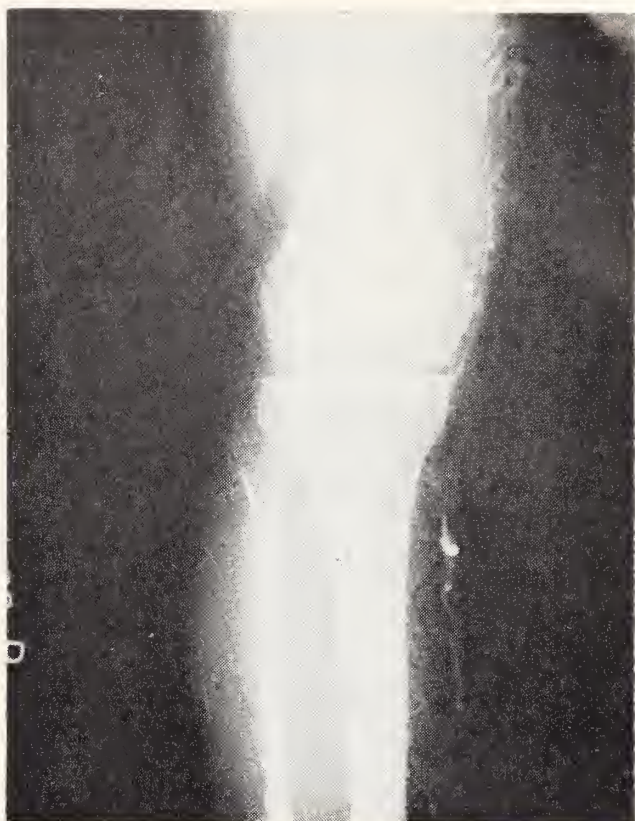


Fig. 4. Case 4. Complete obstruction of all deep veins is demonstrated. Recanalization has not yet occurred. Venous return is accomplished by means of the superficial systems of veins, as shown by the dye-filled tributaries of the greater saphenous vein. Many of the superficial veins are dilated and tortuous, and a few normal valves, such as the one circled, are visualized.



Fig. 5. Case 5. The deep veins are devoid of valves. The deep veins just below the knee and the popliteal and anterior femoral veins show the characteristic features, previously illustrated, of recanalization following thrombosis. Note the abnormal network of dilated, tortuous collateral and superficial veins about the knee.

popliteal and superficial femoral vein. Several large incompetent communicating veins and numerous superficial veins are visualized. Because of other illnesses, no surgery has been done on this patient.

Discussion

Active treatment of the patient with varicose veins presupposes a knowledge of the status of the deep veins. Clinical examination as well as past history may at times fail to provide information as to whether a state of venous insufficiency is primary or postphlebotic in nature. We have found phlebography of great value in this determination. In addition to providing a satisfactory method of deep vein evaluation, phlebography by the technique outlined has been of considerable value in demonstrating incompetent communicating veins between the superficial and deep systems. We believe that this method of phlebography has allowed us to use a more rational approach to a difficult problem.

Our experience with phlebography performed in the horizontal position has been less than satisfactory. Not infrequently incomplete filling of the veins, low intensity of radiographic contrast and poor visualization of valvular structures have been encountered. Phlebography in the erect position which tests the antigravity or functional mechanism of the valves has produced maximal distention of the valve sinuses and high intensity of the contrast. We agree with Hojensgard¹² that from the standpoint of pathology, it is immaterial through which venous pathways the blood flows in the horizontal position, as chronic venous insufficiency gives symptoms only in the erect position where hydrostatic phenomena manifest themselves. Ascending erect phlebography seems to offer the most practical and physiologic method yet devised for the radiographic examination of the patient with chronic venous insufficiency of the lower extremity. Information of both anatomical and functional significance is obtained, and it enables rational selection of surgical procedures.

We do not feel that this procedure is necessary or justified in the usual varicose veins of the extremity.

It is indicated in cases with a definite history of deep thrombophlebitis or where there is any doubt as to the status of the deep venous system. It is useful in varicosities where the etiology may be on the basis of complete or incomplete deep venous obstruction and is frequently helpful in varicose vein problems that have been previous surgical failures. Phlebography is usually done in such cases at this hospital.

Summary

1. The various methods of phlebography are discussed with emphasis upon the technique of ascending erect phlebography.
2. The value of this procedure is outlining rational therapy in difficult problems resulting from chronic venous insufficiency of the lower extremity is discussed.
3. Several illustrative cases are presented.

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Better Health Council

The Better Health Council of Georgia was well represented at a recent meeting on "Teamwork for School and Community Health Education," at Wesleyan College.

In one of the buzz sessions, Mrs. Anna Laura Reid, Executive Secretary of the Council, was asked to set up a maximum school health program. With the assistance of doctors, public health personnel and school superintendents, an ideal program was discussed and many problems which exist over the state were given consideration.

The motivating force for beginning a local health council was the subject for the afternoon session. There were questions about how to organize and have enthusiastic leadership. Some of the points

brought out were: the *need* for a council should be understood; the organization of a council should be timely for the community; select one project to accomplish at a time.

Strong leadership should come from all groups but there should be a small representation in the beginning, later expanding the members to include all civic clubs, official organizations and voluntary and private agencies with health interests.

It was concluded that the community health council can wield more influence in interpreting the program of health in the community than the personnel working with official groups and that these groups meeting and working together tend to diminish wasteful duplication of effort.

ACUTE CHOLECYSTITIS:

Report of 100 Consecutive Cases

*Treated Surgically with No Mortality**

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GALE B. JOHNSON, M.D., New Orleans,

and JAMES B. LITTLEFIELD, M.D., Boston

In the past and to some extent at the present time, a conservative attitude has been adopted by many qualified surgeons in the treatment of acute cholecystitis. It is our opinion and the opinion of many others that acute cholecystitis is similar to acute appendicitis, and deserves essentially the same treatment; namely, early surgical intervention with cholecystectomy or cholecystostomy as may be indicated by the pathology present, the judgment and experience of the surgeon and the general condition of the patient. Barksdale and Johnston² stress in their report that many general practitioners and internists favor the so-called conservative treatment of "watchful waiting" because they have had previous cases which have regressed. These authors also believe acute cholecystitis is as much an emergency as acute appendicitis. In a questionnaire to 151 general surgeons of The Southern Surgical Association, Barksdale and Johnston² found 101 or 66.8 per cent favored early surgical treatment and 30 or 25.1 per cent favored a more conservative care.

In an exhaustive study of personal cases, and a review of the literature Heuer⁸ concluded that at least 20 per cent of cases of acute cholecystitis will have the complications of gangrene, abscess, or peritonitis if a policy of "watchful waiting" is carried out. Glenn⁷ is one of the strongest advocates of early surgical treatment for acute cholecystitis. He has reported 697 patients from the New York Hospital: 429 cases under 50 per cent with a mortality of 1.4 per cent and 268 over 50 with a mortality of 4.9 per cent.

Material

This paper is concerned with the hospital course of 100 consecutive cases of acute cholecystitis, in the white race, treated surgically at the Watts Hospital from 1941 to 1950, with no mortality. These cases were largely private patients and were treated by attending surgeons of the hospital staff with varied techniques. A small percentage of the cases were service patients, which were handled by the resident staff, under the guidance of the visiting staff surgeons.

*From the Department of Surgery, Watts Hospital, Durham, North Carolina.

Age and Sex

Acute cholecystitis is a disease predominately seen from the third through the sixth decade of life. In our series 23 per cent of the patients were over 65 years of age; certainly this is a high figure compared with the percentage of elderly people in the general population. As noted in Figure 1, our greatest number of patients were in the sixth decade. The elderly

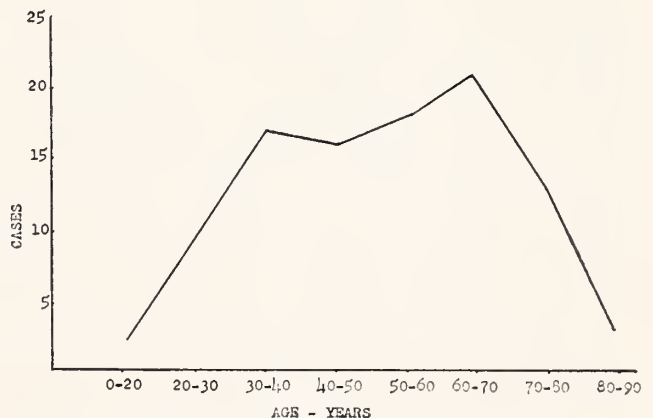


Fig. 1. The age distribution according to decades. The greatest number of patients were in the 60 to 70 age group.

patient is much more likely to develop gangrene and perforation with often only minimal increased clinical signs and symptoms, therefore early surgical intervention is very important in this group. Glenn⁴ found a five fold increase in mortality of patients past 50. Smith¹² reported 332 cases with 24 deaths and 20 occurred in patients past the age of 50.

Acute cholecystitis is certainly much more common in the female sex. Our series revealed a ratio of three females to one male, which is in keeping

with the various reports in the literature. In an editorial on acute fulminating cholecystitis, Patterson¹⁰ intimated that acute cholecystitis was more common in the male, certainly the literature does not bear this out.

Etiology

There are many factors and also many opinions in regard to the etiology of acute cholecystitis. Womack and Haffner¹⁴ attribute acute cholecystitis to three causes: (1) obstruction of the cystic duct, (2) action of entrapped bile on the gall bladder wall, and (3) the occasional secondary bacterial invasion superimposed on chemically damaged tissue. Glenn⁸ has made an interesting observation in regard to acute cholecystitis developing shortly after an unrelated surgical procedure.

Acute gall bladder disease may often be on a chemical basis instead of bacterial. Acute inflammation has been produced experimentally by injecting Dakin's solution intravenously and also by injecting bile salts into the gall bladder. The colon bacillus is rather frequently found in the lumen of the gall bladder; whereas streptococcus and staphylococcus are found in the wall of the gall bladder. Whatever the exact etiology might be, certainly cholelithiasis with a stone blocking the cystic duct plays a prominent part in the development of acute inflammation in the gall bladder.

Diagnosis

The diagnosis of acute cholecystitis should be considered in any patient complaining of severe knife-like pain in the epigastrium and right upper quadrant, which usually radiates along the right costal margin to the tip of the scapula. The pain is usually accompanied by fever, nausea and vomiting. Eighteen per cent of our cases had a normal temperature on admission, and 36 per cent had essentially a normal leucocyte count. This is in keeping with Eliason³ report on 135 cases of proven acute cholecystitis which 21 per cent presented no abnormality of the leucocyte count, 23 per cent had a normal temperature and 4 per cent had no tenderness whatsoever.

Approximately three-fourths of our cases demonstrated fever, nausea and vomiting on admission. Thirty-five per cent of our cases did not give a past history of gall bladder disease, which is a marked contrast to Lester's⁹ report of 91 out of 109 cases with a past history of gall bladder disease. This difference may be due to the fact that a detailed past history was lacking on some of these cases. Unless the patient has a generalized peritonitis, the physical findings are confined to the right upper quadrant, which consist of tenderness, rigidity, spasm and very often a palpable gall bladder is present.

Special Examinations

Laboratory: From Table 1 it is noted that 66 per cent of our cases had a leucocyte count greater than 8,000 and 62 per cent with a polymorphonuclear count in the range of 60 to 90. A normal blood picture does not mean there is no infection present, because Tauroff¹³ found 99 per cent of his patients to have acute inflammation at the time of operation although their signs and symptoms were absent or minimal. Some cases had evidence of acute

TABLE I
WHITE BLOOD COUNT

4,000 to 9,000	36%
9,000 to 15,000	45%
15,000 to 29,000	19%

POLYMORPHONUCLEAR LEUOCYTES

40 to 60	10%
60 to 90	62%
90 to 97	14%
No Differential	04%

The laboratory data in regard to polymorphonuclear count and differential count.

TABLE II
BACTERIOLOGY

No growth in seventy-two hours or longer	Cases 10
B. Coli	21
B. Subtilis	2
Aerogenes	3
Staph. Aureus	1
Alpha Strep.	2
C. Welchii	1
Mixed Infections	3

The type of bacterio isolated from the culture of the gall bladder taken at the time of the operation.

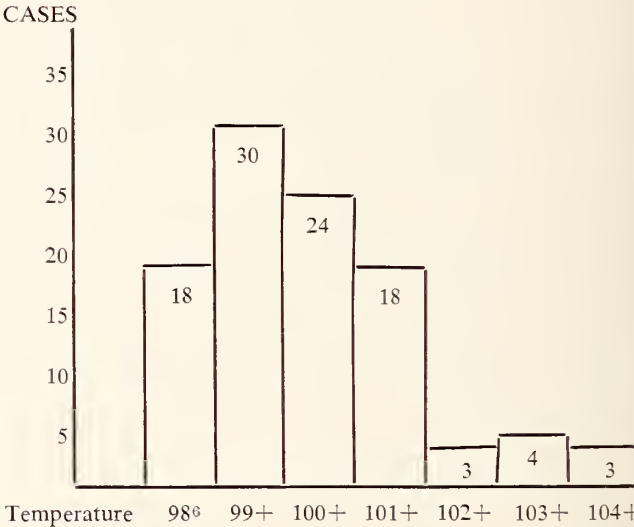


Fig. 2. This figure demonstrates the number of cases in the range of each degree of temperature on admission to the hospital. The majority of the patients were in the 99 to 100 degree temperature group whereas a very few were in the 102 to 104 degree range.

inflammation for as long as three years following the original episode.

Icterus index determinations were made in 49 per cent of the cases and 38 cases were above normal, an incidence of 77.5 per cent. Van den Berg determinations were recorded in 42 per cent of the cases and 27 cases revealed an elevation. More often these elevations are on the basis of inflammation and not common duct stones. Adams¹ reviewed 1,104 cases of choledochostomy and only 50 per cent of them revealed stones in the common duct. Also 50 per

cent of the cases that common duct stones were found did not have jaundice.

Roentgenologic Examination

The examination performed in this series of cases consisted of a flat plate of abdomen and cholecystograms. X-ray examinations were taken in 65 cases; calculi were demonstrated in 22 cholecystograms and in three flat plate of the abdomen. Thirty-five patients had a non-functioning gall bladder. The incidence of demonstrable calculi was 35 per cent.

Surgical Treatment

The operative treatment of choice in acute cholecystitis is cholecystectomy; however, in those cases in which this procedure cannot be carried out expediently and without danger to the patient, cholecystostomy should be performed without hesitation. Glenn⁶ felt that cholecystostomy is indicated in (1) if patient cannot stand more extensive surgery, (2) cholecystectomy is too difficult technically, (3) extremely old patient with debilitation. In our series cholecystectomy was performed in 74 cases, sub-total cholecystectomy in 11 cases and cholecystostomy in 15 cases. The common duct was explored in only four cases. There were 84 patients drained with rubber tissue and 16 were closed without drainage.

A sub-costal type of incision was used in 59 cases, an upper right rectus incision performed in 33 instances and an upper transverse incision was employed in eight cases. All of the surgical specimens were examined by the Department of Pathology and diagnosed as acute cholecystitis. The few cases in which cholecystostomy was carried out without biopsy were diagnosed as acute cholecystitis by the gross pathological findings at operation. Calculi were demonstrated in 84 cases and 14 of this group were of the single solitary type. Chemotherapy is a useful adjunct to surgery, but should not be depended upon for the primary treatment.

Postoperative Complications

Eighty-three percent of these patients did not experience any post-operative complications. There were three cases that developed post-operative shock, which responded readily to treatment. Pneumonia developed in three patients, which resolved with chemotherapy. The only other chest complications consisted of two cases of atelectasis, which subsided rapidly to conservative measures. Wound infections were present in only two cases.

A patient in whom the common duct was explored developed a stricture, which necessitated a subsequent plastic repair. Other complications consisted of one instance of each of the following: (1) a generalized peritonitis, (2) external biliary fistula, (3) draining sinus from operative site, (4) a prolonged febrile course without a definite explanation, (5) severe persistent cystitis, (6) phlebitis, and (7) a questionable case of coronary occlusion.

Discussion

Although acute cholecystitis occurs in all age groups, we believe the treatment of choice is the same in the absence of positive contra-indications to surgery. Acute cholecystitis is in our opinion an

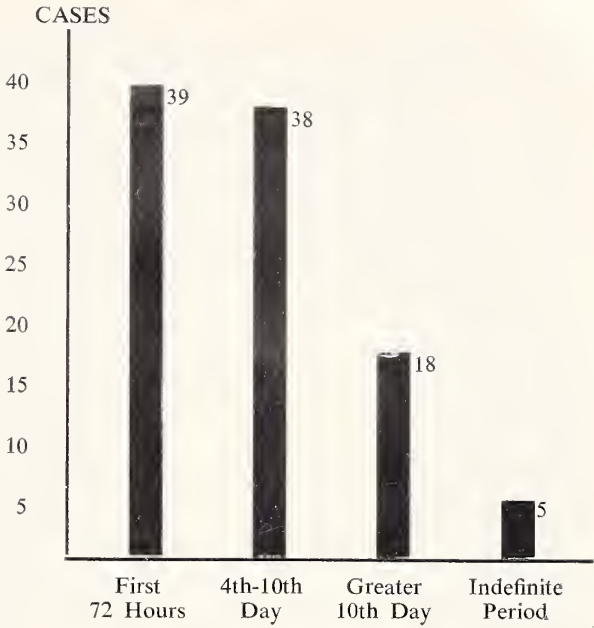


Fig. 3. This illustration depicts the time of illness prior to surgery. Note the great number of patients operated on from the fourth to the tenth day.

acute surgical condition and if admitted on a service other than surgery should have the benefit of early surgical consultation. According to Barksdale and Johnston² each additional attack of acute cholecystitis increases the mortality by approximately 2 per cent.

Many surgeons have advocated operative intervention only within the first 72 hours of the illness; the so-called "critical period". Ross et al¹¹ found very little difference in the so-called "critical period" and the fourth to the twelfth day period in regard to the patient and the technical difficulties of the operative procedure. Sixty-one per cent of our cases were operated on after the 72 hour period. We agree that early hospitalization followed by early diagnosis and operative intervention, when the patient has been adequately prepared is the ideal treatment, but the patient past the "critical period" should have early surgical treatment unless there are severe contraindications.

If the patient is not operated upon promptly the hospital stay is prolonged and their expense is increased. The chances of abscess formation, gangrene, and perforation are increased; and subsequent symptoms will almost certainly require surgical relief. In Ross et al¹¹ series 47 patients operated on after the twelfth day had a hospital stay of 25.7 days and 67 patients operated on in the first twelve days had a hospital stay of 16.7 days. Many of these patients suffer from chronic diseases, such as heart disease and diabetes, and the persistence of this nidus of infection complicates the pre-existent disease. Heuer⁸ was of the opinion that chronic cholecystitis predisposes to arteriosclerosis, hypertension and myocarditis. Many of these chronic diseases often show improvement and are more easily managed after removal of a diseased gall bladder.

Free perforation into the peritoneal cavity is an unusual complication when compared to perforation into the liver, omentum and intestines; but when it does occur, it is usually fatal. The prediction of the extent of necrosis of the gall bladder wall is difficult and risky especially in patients who are past 50 years of age. The postoperative response experienced by these patients with their relief of pain, fever, nausea, vomiting, and their early feeling of well-being is most dramatic.

Conclusions

(1) The patients with acute cholecystitis should have early operative treatment after being properly prepared for surgery.

(2) The morbidity, mortality and the length of the hospital stay in these patients are decreased in those who have operative treatment.

(3) The age of the patient per se is not a contraindication to surgery; in fact, the elderly patient needs surgery more urgently than the younger group.

(4) Although it is much more preferable to operate within the first seventy-two hours of the illness, patients in our series who were operated after this lapse of time did as well as those operated in the critical period.

(5) The diagnosis of acute cholecystitis should be made on the history and clinical findings, supplemented by laboratory procedures; but one should guard against laboratory findings that do not support the clinical picture.

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PRIMARY VARICELLA

Prior to 1953, the literature contains only rare reports of virus pneumonia accompanying varicella. Bullova and Wishik¹ reported 21 cases of pneumonia among 2,534 hospitalized cases of chickenpox, but in these instances it appears that bacterial lung infections (hemolytic streptococci) secondarily complicated the disease. Ten cases^{2-8 11 12} of primary varicella pneumonia, in which the pulmonary symptoms paralleled the invasive period of the exanthem, and were presumably due to the chickenpox virus, were described before 1953. Four of these cases ended fatally,^{3 4 5 11} and in two of them^{4 5} characteristic type A intranuclear inclusion bodies of varicella were found in alveolar septal cells and macrophages, and in bronchiolar epithelial cells, at autopsy. Otherwise, the findings in all four patients were similar to those found in other types of virus pneumonia. Recently, four more cases^{9 10} have been reported, all of whom recovered.

Saslaw, Prior, and Wiseman¹⁰ reviewed three cases of severe varicella pneumonia that came to their

PNEUMONIA

JOHN F. STEGEMAN, M.D., Athens

attention within a five-month period. All were adults (aged 28 to 42), all developed pulmonary symptoms shortly after the appearance of skin vesicles, and all demonstrated severe dyspnea, cyanosis, and hemoptysis in addition to the usual symptoms of virus pneumonia. All three had few, if any, physical signs on chest examination, which was in remarkable contrast to the severity of the findings on X-ray. The chest plates in all the cases showed a diffuse bilateral nodular infiltration of the lung fields. White cell counts ranged from 4,300 to 13,400 with normal differential studies. Sputum cultures failed to isolate significant pathogenic bacteria. Two patients were treated with penicillin and one with aureomycin. All were afebrile and improved by the third hospital day.

although one later developed a pulmonary infarct secondary to phlebothrombosis of both legs. It was noted that the pneumonic symptoms in general subsided coincidentally with the drying of the skin lesions.

Rosecan, Baumgarten and Charles⁹ reported a case of varicella pneumonia in a 36-year-old man, which was complicated by shock and heart failure prior to ultimate recovery. In addition to other symptoms of circulatory collapse, he exhibited marked shortness of breath, cyanosis, and hemoptysis. Besides supportive drugs used to combat shock and cardiac decompensation, he received large doses of streptomycin and penicillin. Convalescence was extremely slow.

CASE REPORT

J. D., a 30-year-old student and office worker, whose small daughter recovered from chickenpox two weeks previously, developed chills and fever on February 28, 1953. On the following day, the fever became more marked and he noted the eruption of small papules and vesicles on his trunk. These lesions rapidly became widespread, and a hacking cough developed. On the third day of illness the cough became worse, and the patient began bringing up blood-streaked sputum. At this time his breathing became rapid, and his temperature rose to 103 degrees F. It was not ascertained whether cyanosis was present. The patient, who lives in the country, was able to keep in telephone contact with his physician, but no visit was arranged early in the disease, as it was assumed the patient had merely a severe case of varicella. No antibiotics were prescribed. On the fourth and fifth days of illness, he became progressively better, and on the sixth day he was afebrile and without symptoms other than weakness. On this day, the patient reported to his physician's office for a check-up and chest X-ray.

Physical examination revealed a patient in no distress but completely covered with varicella lesions, mostly in late stages and beginning to dry. Temperature was 98.4 degrees F., pulse rate 90, and respirations quiet, slow, and regular. The heart was normal. The lung fields were clear to percussion and auscultation. The remainder of the physical examination was not remarkable.

Chest X-ray (Fig. 1) revealed an extensive miliary infiltration throughout both lung fields, somewhat heavier on the right.

In spite of the disturbing chest film, the patient had recovered from practically all of his respiratory symptoms, and hospitalization was not considered necessary. In view of the X-ray findings, and in spite of his clinical recovery, he was placed on one gram of aureomycin daily. Four days later, the patient had completely recovered except for rapidly disappearing, crusty skin lesions. A chest film on this day (Fig. 2) showed resolution of the pulmonary infiltration.

Summary and Conclusions

It is evident that a severe type of virus pneumonia sometimes accompanies chickenpox, and it is believed that the causative agent is the varicella virus itself rather than a complicating organism. The following statements appear to be applicable to the cases reported.

(1) Primary varicella pneumonia is peculiar to adults. Despite the tremendous preponderance of juvenile chickenpox, primary lung involvement does not appear to occur in pre-puberty groups.

(2) The pulmonary involvement occurs during the invasive stage of the exanthem, appearing soon after the eruption of vesicles.

(3) The cardinal symptoms, in addition to the usual findings of virus pneumonia, are severe dyspnea, cyanosis, and hemoptysis.

(4) Chest X-ray is characteristic in that extensive

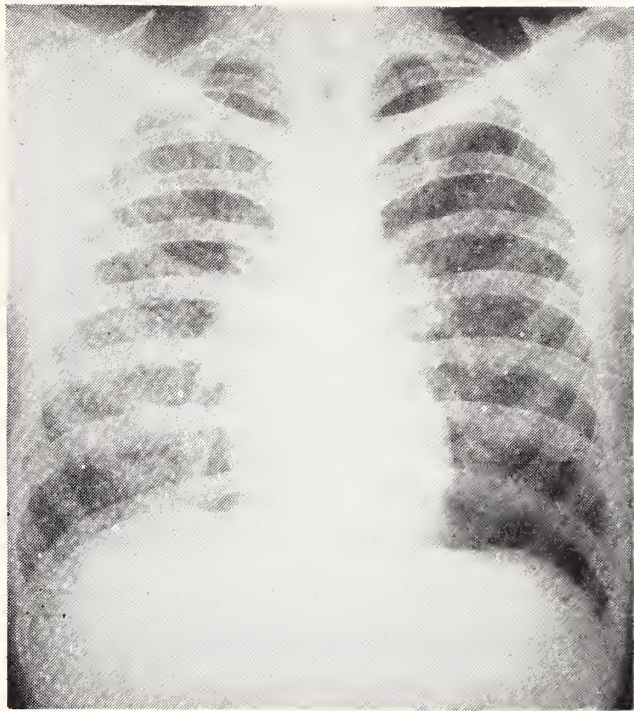


Fig. 1. Chest plate taken on March 5, 1953, on sixth day following onset of illness.

nodular or miliary infiltrations are widespread in both lung fields.

(5) Percussion and auscultation of the chest may reveal little or nothing.

(6) Leucocyte counts are not characteristic, but are usually depressed or only slightly elevated, with normal differential counts.

(7) Significant pathogenic bacteria are not isolated from the sputum.

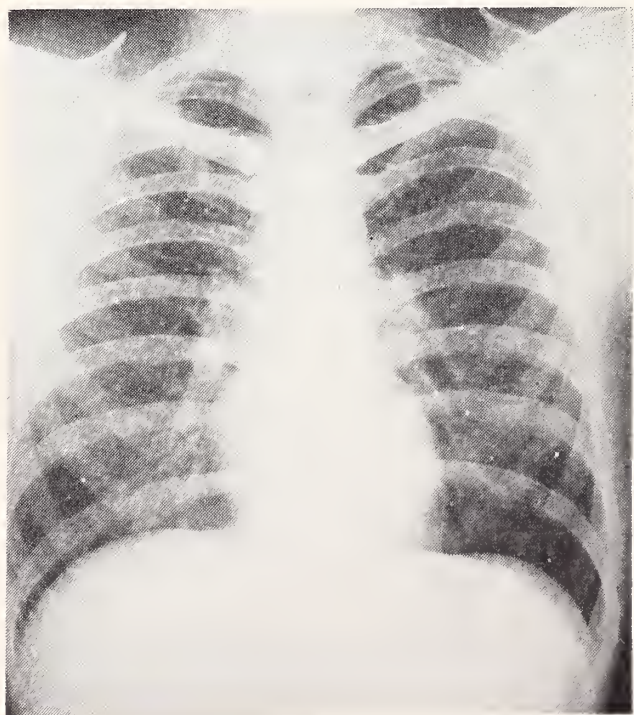


Fig. 2. Chest plate taken on March 9, 1953, four days after original film.

(8) Different antibiotics have been used without evidence of one being more or less successful than any other. In the case reported in this paper, clinical recovery occurred spontaneously before an antibiotic was used.

(9) Primary varicella pneumonia may be very severe. Four deaths occurred in 15 reported cases.

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Special Articles

(Socialized Medicine; or the placement of medical, surgical, dental, nursing and other similar health services under government control in Washington.)

Shall ONLY The

DOCTORS FIGHT IT OUT?

P. O. CHAUDRON, M.D., Cedartown

Compulsory regimentation of the medical arts would abolish all voluntary choice of the kind, amount and character of insurance, would kill business competition which produces better service, would be monopolistic, political and open the flood gates of the tax payers' purses. Government now takes over 25 per cent of the national income and is still running in debt—with no end in sight. This added burden may diminish the efforts expended in better sanitary housing, adequate food, education, healthful recreation and voluntary contributions to research work and charitable organizations.

The Life Insurance Association of America, representing the life insurance companies which write approximately 95 per cent of the life insurance in force in the United States today, with long experience in medical and vital statistics, and in the prepayment cost of hospital and medical care, add emphasis to the fact that "there is no health crisis in the United States." They add; "The overall death rate has been reduced 40 per cent since 1900; the space of life has been nearly doubled since our republic was founded, i.e.: 35 to 67 years."

Infant mortality has been reduced 50 per cent, and maternal mortality has been reduced 80 per cent

in the last 20 years. These figures do not indicate a health crisis' in this country, as the proponents of compulsory medicine would have you believe.

Let us see what has been attained on a voluntary basis. Starting from scratch in 1930, Blue Cross has 31,000,000 enrolled. In this and other similar organizations, in life insurance companies, and under industrial set-ups, it is now estimated that 61,000,000 are voluntarily insured against the cost of hospital care. There are 34,000,000 insured for surgeons' fees—an 8 million increase in 1948 alone! Voluntary insurance against medical care, (not included under hospitalization) Surgeons' Fees insurance is the newest in the field, with 13,000,000 members already. Should we destroy it with an expensive, doubtful program in line with similar compulsory systems so poorly conducted in some other countries?

Like the Chamber of Commerce of The United States, the National Affairs Committee of the Columbus, Ohio, Chamber, proposed a resolution to its Board; "that the Chamber be authorized to take any and all action necessary to defeat any program of socialistic compulsory health insurance that is proposed."

The State of Washington on January 1, 1949, passed the Citizens Security Act . . . which offered—"it would guarantee anyone on the state relief rolls, free medical care—physicians, hospitalization"—even crutches and false teeth! It would in effect make Washington the first "welfare state." After seven months, health costs have zoomed more than 150 per cent above a year ago. The State Social Security Director conceded that "abuses have developed . . . that it is possible for a person in need and unemployed to draw more money than he earns producing."

"Relief families get everything from diapers to funerals free. Program now is taking about half the State's tax money—and the cost is going higher. In Yakima County 25 families with dependent children are receiving more than \$300.00 a month in State benefits. These benefits exceed the earnings of many workers with families of the same size. Unemployed workers sometimes prefer to stay on relief to taking jobs when they open up. There is growing fear that education and other State functions will suffer. Criticism is raised . . . by those who are alarmed by the State's ever-growing budget.³

Sir Stafford Cripps, British Chancellor of the Exchequer says: "We must recognize the unpleasant fact that these (the rising cost of social services) must be paid by taxation, direct or indirect—now more than 40 per cent of the national income, and already falls to a considerable extent upon those who are the recipients of these services." From New Zealand's Director-General of Health: "Whatever form or measure of service, it must be paid for, however indirect the payments may be." Roger W.

Babson, noted financial adviser says: "It is your money which is being spent on all 'security experiments.' All these 'social programs' means higher taxes for you."³

In an article in *Readers Digest* of May 1949, entitled "Lessons from Britain's Socialistic Experiment," Alfred Edwards, Member of Parliament, and former member of the Labor Party, says: "The situation today is very serious for England. The Labor Party runs the State, and the trade unions own the Labor Party. The Miners' Union is dominated by its secretary, Arthur Horner, a Communist who has announced publicly, that if England goes to war with Russia, there will be no coal!"

General Dwight D. Eisenhower said: "Unless we are careful, even the great and necessary educational processes in our country will become yet *another* vehicle by which the believers in paternalism,—if not outright socialism—will gain still *additional* power for the central government."⁵

General Omar N. Bradley, Chief of Staff, U. S. Army, in *Readers Digest* states: Too many of us are inclined to see Washington as the source of the bountiful life. Apart from its economic implications, turning to Washington with our troubles conceals a political danger as well. We cannot look to government for its benefits and deny it our obligations, for overdependency on government is the road to enslavement."⁶

Even the British Worker, the one who was supposed to get the benefits of Socialism, is complaining that he has a hard time getting along. By U. S. Standards the worker's income is low and his taxes high. The working class, as well as the wealthy class, is having to help pay the cost of Socialism.

David Lawrence, Editor, under "Conservative Liberalism vs. Radical Liberalism": "The radical liberal believes in the repudiation of public debt . . . seeks to use the power of taxation to reduce individual incentive and pave the way for state socialism."⁷

Former President Hoover, says: "Government spending and taxes threaten the nation with collectivism—our nation is blissfully driving down the back road to collectivism. Along this road of spending the Government either takes over—which is socialism—or dictates institutional and economic life—which is fascism. The American mind is troubled by the growth of collectivism throughout the world."⁸

Roger Babson says: "We are undermining democracy." "When medicine is socialized, when doctors and their patients are regimented, the beginning of the end is in sight. It is one of the final, irreparable steps toward complete state socialism. And at the end of that road is human degradation and misery;

loss of incentive, loss of human dignity, loss of everything that means most to free men."⁹

Lexington Jones, of Christ Church, New Zealand, having worked in a socialistic state for many years, makes these observations: "The system as operated in New Zealand allowed itself of such abuse that it has almost become a farce. The average cost (through taxation) to each individual is \$60.00 per annum. Lenin said 'Socialized medicine is the keystone to the arch of the Socialistic State.' In New Zealand they have been true to form. Since 1941 the New Zealand government has brought under its powers, the Bank of New Zealand, the dental professions, chemists, masseurs, the National Airway, etc. This procedure merely goes to prove that the regimentation of the medical profession was the forerunner of a carefully calculated procedure as outlined by the fellow-travelers—the Communists. Don't say 'it cannot happen here in America.' New Zealand said it, and so did every other country that is now under the heel of dictatorship. It can, and it will, unless you oppose it with all the strength you can muster."¹⁰

Roger Babson, a great believer in personal initiative and effort, succinctly states: "It is immeasurably harder through sweat and labor and honest industrial effort to *remain* free than to *become* a slave, and in his Reports of June 27, 1949 comments;" . . . we believe that passage of the bill (S.1679) would actually be a decisive, if not irrevocable, step toward socialized medicine in the U. S. Medical care is indeed a national obligation, but it is a public duty rather than an exclusive government function. We know that private enterprise can do almost any given job a lot better than government. Why, then, do we not have the backbone to take it from there and prove the point?"

Federal socialism of medicine is the entering wedge of socialism in many, and perhaps eventually, all other fields of endeavor, and is different in name only, from other collectivist systems, whether totalitarianism, nazism, communism, or fascism; leading eventually to domination and enslavement.

In our Congress, both in the Senate and in the House we have hundreds of friends of the real American way of life, who are opposed to the socialization of any profession or industry.

One has but to read some of the addresses in Congress by such men as Hon. Forrest A. Harness, M. C. from Indiana; or Hon. Frederick C. Smith of Ohio, who stated: "Probably the worst of all of the bad features of social insurance, is the fact that when this parasite once gets its suckers well fastened into the vitals of a nation, nothing short of either

national bankruptcy, a dictatorship, or a revolution will be able to loosen its hold." Hon. Walter C. Ploeser, M. C., Missouri, and Hon. Roy O. Woodruff, M. C., Michigan, have likewise expressed themselves, the latter presenting an article: "Political Medicine." by Mr. Merit K. Hart, President of the National Economic Council, Inc., which in part, states: "The American people do not have to have this scheme, fathered by communism, mothered by socialism, and wet-nursed by power-hungry bureaucracy, imposed upon them. It is not inevitable. Nothing that limits freedom is inevitable so long as enough free men and women have the courage to stand up and fight against it."

Mr. Thurman Sensing, Director of Research, Southern States Industrial Council, Nashville, Tenn., in a pamphlet "Wake Up, America," states: "I have just returned from an eight weeks visit to Great Britain, where I studied at first hand the results of a socialistic government in action and observed its effects upon the freedom and economy of the people. Great Britain was in no position to afford such benefits (i.e.; the 'free' welfare benefits promised the people by the Socialistic Government), and they could by no means have been provided—without aid from the United States—aid, by the way, that was created by private enterprise and paid by American tax-payers."

Hon. Robert A. Taft stated: "In the first place, the Truman proposal is not insurance at all. It is a proposal to change the whole system by which medical service is obtained in the United States. The term 'insurance' is used simply because insurance is generally popular, and it is hoped to make the bitter pill more acceptable. The plan apparently provides the poorest type of medical service; . . . decreasing the quality of service. We cannot go much further in that direction, either in the general field of economic control or in the comprehensive providing of welfare services from Washington, unless we do wish a completely totalitarian state. . . . Furthermore, the average man has no voice in the operation of a Washington bureau. Washington is confident of its own superiority, and its general attitude is that the public is 'too damn dumb' to understand. . . . Administration by *States* and *local* government is generally democratic. Administration by Washington *boards* and *bureaus* is tyrannical. . . . The political patronage involved would be tremendous. . . . All Federal bureaus of this nature are notoriously inefficient, expensive and political. We must determine whether we are going to turn our destiny to a bureaucracy of self-styled experts. I cannot conceive of a measure which will more greatly extend an all-powerful central government, than federal compulsory health insurance. The whole country will not be forced into the strait-jacket of an ideology which controls a few experts (?) in Washington. Freedom is the greatest assurance of progress in the field of medicine as in every other phase of American life."

It behooves every person who reads this, whether doctor or not, to take the time to write his Senators and Congressmen, voicing positive opposition, and seeking their support in defeating this or any other compulsory plan for medicine, or any other profession or industry.

If a system can, and it probably will, be worked out for giving better health service to those unable to pay, without a sudden, drastic, revolutionary and domineering centralized government plan, with innumerable federal employees, most of whom would probably be unfamiliar with the needs for, and the application of remedial measures, that would be well. But the benefits to be derived by those for whom the bill is supposed to help, would be meagre for the amount paid through added taxation, and another bureaucratic department of government would be installed, to the detriment of free enterprise.

We might well mention the estimated cost, and the proposed plan of administration of such a service. Our experience would probably not differ greatly from other countries. In Britain it was underestimated by 40 per cent, for the first nine months, and in New Zealand, it has risen 50 per cent in the last five years and has taken 40 per cent of all its revenue, yet, in its tenth year of existence there no level has yet been reached.

As concrete examples before our eyes in our State of Washington, in Britain, in New Zealand, we can visualize the enormous burden of its added costs and the subjugation of our national pride, not only for the present, but for the future. In the federal plan of taking 1½ per cent for the employee's wage, and another 1½ percent from his employer, a total of three per cent is used as a starter.

What will be the cost of the Wagner-Murray-Dingle Bill (S. 1679)? (Estimates run from \$4 billion to \$18 billion a year.)

Oscar W. Ewing, chief government advocate of the W. M. D. plan, parries this question with: "The cost might run somewhere between \$4 billion and \$6 billion each year. Payroll deductions would then amount to perhaps four per cent." His optimism is not shared by many actuaries. Elizabeth W. Wilson, a former actuary in the Social Security Administration, estimates: "It appears probable that health insurance would cost more than eight per cent of the payroll of the insured workers during the next ten or fifteen years. It would be a load of \$7 billion by 1960." "Effort has persistently been made," says *Christian Science Monitor*, "for the past ten years to sell the American public something calling for a huge expense without giving an accurate forecast of the ultimate cost. That may be ingenious, but it is poor business policy."¹¹

Let's look at the five-man Federal board that would run the program. According to (the bill) S. 1679, this group would consist of the Surgeon General of the U. S. Public Health Service; the commissioners for Social Security; and three Presidential appointees—at least *one* of them a physician." There are indications that the plan may not have even five, but only one man in control. According to S. 1679 the

National Health Insurance Board would run the program, "under the direction and supervision of the Federal Security Administration." In the opinion of Senator Forrest Donnell of Missouri—"This certainly vests all authority in *one* man—who does *not* have to be a doctor."¹² A political football of gigantic magnitude.

We doctors should and do feel a sense of gratitude that the quoted remarks above were from men and women who are *neither physicians nor surgeons*, but a cross section of true blue Americans who realize the fight is *not* one for the doctors only.

Shall only the doctors fight it out?

To the uninformed, this may be a natural question or be easily dismissed with that assumption. One may think that only the doctors are concerned. The doctors *are* (like all other citizens *should be*), *very much concerned*. However, the matter does not rest only with the doctors. Each worker—each wage earner—is directly and vitally concerned with the wording, the implications and final results of this proposed legislation.

Let's take some hard facts into consideration. Should such socialistic legislation be approved, it will immediately effect the 56,000,000 "workers" in our land.

Doctors, like lawyers, merchants, dentists, mechanics, nurses, grocers, engineers, ministers, salesmen, and all others who make up the economy of our country, are "workers" also, and are included in that 56,000,000.

There are approximately 180,000 active doctors in our country. This means one *doctor* "worker" to every 300 *other* "workers." When the noose is placed around the neck of one doctor, the other 299 workers must submissively yield to the yoke—too late to decide whether "wanted or not."

Certainly no one wants that who has, or who will take time to think before leaping into that Utopia of "Free (?) Medical Care." The sooner we learn that nothing is free, that any and all the blessings of life are gotten through personal initiative, hard work, honest endeavor and a pride in our freedom to make our own way, the sooner we will realize that the tempting morsels of "free" things are a bait leading to the stepping stones of paternalism and political serfdom and are the vilest snares and delusions.

Let's not take it lying down. Let's fight for our God-given freedom, and for the principles upon which this land of ours was founded, and upon which, with the *proper effort* on *our* parts, will *continue* to flourish in freedom and prosperity.

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8—James M. Hicks, Brunswick.....	1956 Session
9—Charles R. Andrews, Jr., Canton.....	1954 Session
10—J. Victor Roule, Augusta.....	1954 Session

COMMITTEE APPOINTMENTS FOR 1953-54

(In accordance with Chapter VI, Secs. 1, 2 and 4, Constitution and By-Laws of the Medical Association of Georgia, the President shall be a member of *all* committees; the President-Elect, an ex-officio member of all *standing* committees; and the Secretary-Treasurer, an *ex-officio* member of all committees of the Association.)

By-Laws: Chapter IX, Sec. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required, with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint an-

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Medical Association of Georgia

1953-1954

other member to fill his unexpired term. All committees shall make an annual report in writing to headquarters offices, 60 days in advance of the Annual Session.

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SCIENTIFIC WORK

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 1957; Third District: R. C. Montgomery, Butler, Sept. 1, 1954;
 Fourth District: M. M. Head, Zebulon, Sept. 1, 1955; Fifth
 District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954; Sixth
 District: A. M. Phillips, Macon, Sept. 1, 1956; Seventh Dis-
 trict: Fred H. Simonton, Chickamauga, Sept. 1, 1956; Eighth
 District: C. J. Malloy, McRae, Sept. 1, 1956; Ninth District:
 R. Lee Rogers, Gainesville, Sept. 1, 1956; Tenth District:
 Thos. W. Goodwin, Augusta, Sept. 1, 1955; *Georgia Dental*
Association—J. M. Hawley, Columbus, Sept. 1, 1958, J. G.
 Williams, Atlanta, Sept. 1, 1958; *Georgia Pharmaceutical As-*
sociation—Preston Sumner, East Point, Sept. 1, 1953; A. T.
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Report of

COUNCIL MEETING,

Atlanta, June 14, 1953

The Council of the Medical Association of Georgia met on Sunday, June 14, 11:00 a.m., in the Academy of Medicine, Atlanta, with the following present: H. L. Cheves (Chairman), William P. Harbin, Jr., David Henry Poer, D. Lloyd Wood, Mark Dougherty, Jr., H. Dawson Allen, Peter B. Wright, Charles T. Brown, W. G. Elliott, George R. Dillinger, J. G. McDaniel, Neal F. Yeomans, James M. Hicks, Eustace A. Allen, John L. Elliott, and Messrs. Milton Krueger and Sid Wrightsman, Jr.

The following action was taken:

1. Amend items 2 and 8 in published report of May 13 organizational meeting of Council (*JMAG*, Vol. 42—No. 5) to read:

"2. Approved salaries and Headquarters Office operating expense items as included in the 1953-54 budget as presented by the Audit and Appropriations Committee.

"8. Authorized President-Elect Wright's attendance (without vote) at future meetings of the Council Executive Committee."

2. Ordered published in an early issue of *The Journal* the expense breakdown of the 103rd Annual Session, Savannah, May 10-13, 1953.

3. Approved dates of May 2-5, 1954, for holding of 104th Annual Session at Macon.

4. *Designated* Allen (Chairman), Elliott and Dillinger to comprise Council Committee on Arrangements for the '54 Annual Session, with W. R. Golsan, Macon, as General Chairman of Local Arrangements Committee.

5. *Authorized* payment of \$850.00 to Auxiliary Treasurer, representing Association donation of \$600.00 for Auxiliary publication expense, and \$250.00 for Auxiliary President and President-Elect travel.

6. *Appointed* Chambers (Chairman), Dougherty and Wood as Council Committee on Audit and Appropriations.

7. *Authorized* donation of \$1,000.00 to the Crawford W. Long Memorial Museum, as recommended by the House of Delegates.

8. *Authorized* annual contribution of \$1,000.00 to Better Health Council of Georgia.

9. *Heard* verbal report on AMA Annual Session in New York City (June 1-5) by AMA Delegate Eustace A. Allen.

10. *Designated* Mark S. Dougherty, Jr. as Assistant Secretary-Treasurer of the Medical Association of Georgia.

The meeting adjourned at 1:20 p.m.

Report of INSURANCE BOARD

Meeting, Atlanta, June 14, 1953

A meeting of the Insurance Board of the Medical Association of Georgia was held Sunday, June 14, at 10:00 a.m., in the Academy of Medicine, Atlanta. The following members of the Board and officers of the Association were present: William Harbin, Peter Wright, David Henry Poer, W. S. Dorrough, John L. Elliott, D. Lloyd Wood, Ottis E. Hanes, David R. Thomas, George Dillinger and Messrs. Sid Wrightsman, Jr., and Milton D. Krueger.

W. S. Dorrough chairman of the Board for several years has retired from the Board at his own request making some reorganization necessary.

John L. Elliott was elected chairman. In tentatively accepting the position of chairman, Elliott emphasized the responsibility of this Board to the people of Georgia and the physicians of Georgia. He requested that the Board be set up as originally designed, to include a physician from each medical district elected by the members of that district to represent them and to serve them during their pleasure. It should also include the laymen as originally planned and approved by council in 1948.

Elliott then requested that a co-chairman and a secretary be elected. Ottis E. Hanes was elected co-chairman and Mr. H. B. Coolidge of Savannah was elected to membership on the Board and chosen secretary.

The Board discussed and agreed upon a few of the fundamental principles involved in the problem of furnishing medical care to families in the low income brackets.

The cost of hospital and medical care has been spiralling upward until it is often a serious strain on

the family budget. While relatively small, percentage wise, compared to gasoline, alcohol, tobacco, cosmetics and candy, the cost of illness always comes as a shock, unexpected. A few, frugal families may be prepared for it, but most families in the low income groups need help. The physician occupying a position of trust in the family and community councils is the logical person to assume the leadership in working out some plan of assistance. Our neighbors and friends want to continue to pay their just obligations, medical and otherwise. If we help, most of them should be able to do this and retain their cherished independence and liberties.

This we should do as a public service. If in the performance of this service the prestige of the physician is elevated a bit in the family and community councils, or if a slight profit accrues to him and the danger of Socialized Medicine is made a little less imminent, these are by-products and not the main objective. The main objective, the goal toward which we strive is to be able to provide the best medical care of which we are capable, the best medical care the world has ever known, to all of the people of Georgia all of the time at a premium that even the low income groups can pay.

The immediate objectives are to complete the reorganization of the Board, elect an executive committee and set about the task of revising the fee schedules and adding such services as appear feasible from time to time.

This whole plan was submitted to council by Elliott. Council approved the plan and will underwrite the expense.

The Board hopes to meet again in Savannah about the middle of July.

PERSONALS

M. C. Adair, of Washington, recently moved into a new modern office building containing six well equipped rooms. The building is located just beyond the Washington General Hospital.

Carl C. Aven, of Atlanta, was elected at the 19th meeting of the American College of Chest Physicians, as Historian for the year 1953-54.

Robert L. Bennett, of Warm Springs, was recently appointed Medical Director of the Georgia Warm Springs Foundation. Assistant medical director in charge of physical medicine at Warm Springs for many years, Dr. Bennett is also professor of physical medicine at Emory University School of Medicine.

W. W. Buckhaults, of Atlanta, announces the opening of an office at 103 East Jones Street, Savannah for the private practice of ophthalmology. He was recently certified by the American Board of Ophthalmology after completing a three year residency in ophthalmology at Grady Memorial Hospital, Atlanta.

W. L. Bridges, a Tifton pediatrician spoke to the Tifton Lions Club on the present progress in the treatment of poliomyelitis.

James Bryant, of Newnan, has recently moved into his new office building, located at 32 Jackson Street. The building, formerly a residence, has been attractively remodeled throughout.

R. L. Carter, of Hancock County, is discontinuing his practice for at least a year at which time he may return to a limited practice. After 33 years, 3,000 babies, 17 cars and a life-time of experience in Thomaston, R. L. Carter says "I'm not retiring or taking a vacation. I'll probably spend a year building a small cottage and improving the cattle farm. We'll be back all along. Thomaston is still home."

Braswell E. Collins, of Waycross, has moved his offices from Waycross to 959 Daisy Park, Macon. Practicing with B. H. Minchew in Waycross since 1938, Collins is an eye, ear, nose and throat specialist.

Albert Evans, of Atlanta, was recently elected president of the Mercer Alumni Association at the annual meeting of the Association in Macon.

Veterans Administration announces the appointment of *Wilton Monroe Fisher*, of Atlanta, as chief of the residency and internship section, research and education service, in the Central Office, Washington, D. C.

J. E. Garner, of Thomaston, attended the annual meeting of the Medical Alumni Association of the University of Maryland held at Biltmore June 4. Garner was the recipient of a Fifty-Year Service Award given by the MAG at their recent Annual Session, and was also awarded a certificate of recognition for his 50 years of service to the profession by the Medical Alumni Association.

Hugh A. Goodwin, of Summerville, was the principle speaker at the Business and Professional Women's Club meeting recently held at the Riegeldale Tavern, Summerville. The topic of his address was the many aspects of public health.

W. A. Hendry, Blackshear, is now studying at the Cook County Postgraduate School of Medicine, Chicago. His course of study will continue throughout the month of June.

Henry S. Jennings, Jr., of Atlanta, has recently been elected to membership in the Atlanta Clinical Society.

John Martin has assumed the practice of *R. J. Hooper*, at 302 Professional Building, Macon. Hooper will spend a year in the Air Corp. John Martin received his specialty eye training at Tulane University, New Orleans, Louisiana, and the Jefferson Hillman Hospital, Birmingham, Alabama after being in general practice in Louisville, Kentucky for two and one half years.

Malcolm T. McGoogan, of Waycross, was guest speaker at a recent meeting of the Blackshear Rotary Club. The subject of his talk was "Cancer."

At a recent meeting of the Atlanta Radiological Society the following officers were elected: President—*Calvin B. Stewart*; Vice-President—*Ted Leigh*; Secretary—*Albert A. Rayle, Jr.*, all of Atlanta.

DEATHS

COCHRAN: *M. F. Cochran*, 61, of Newnan, died in Newnan June 17. An eye, ear, nose and throat specialist, he was a native of Barnesville and graduated from Vanderbilt University School of Medicine, 1914.

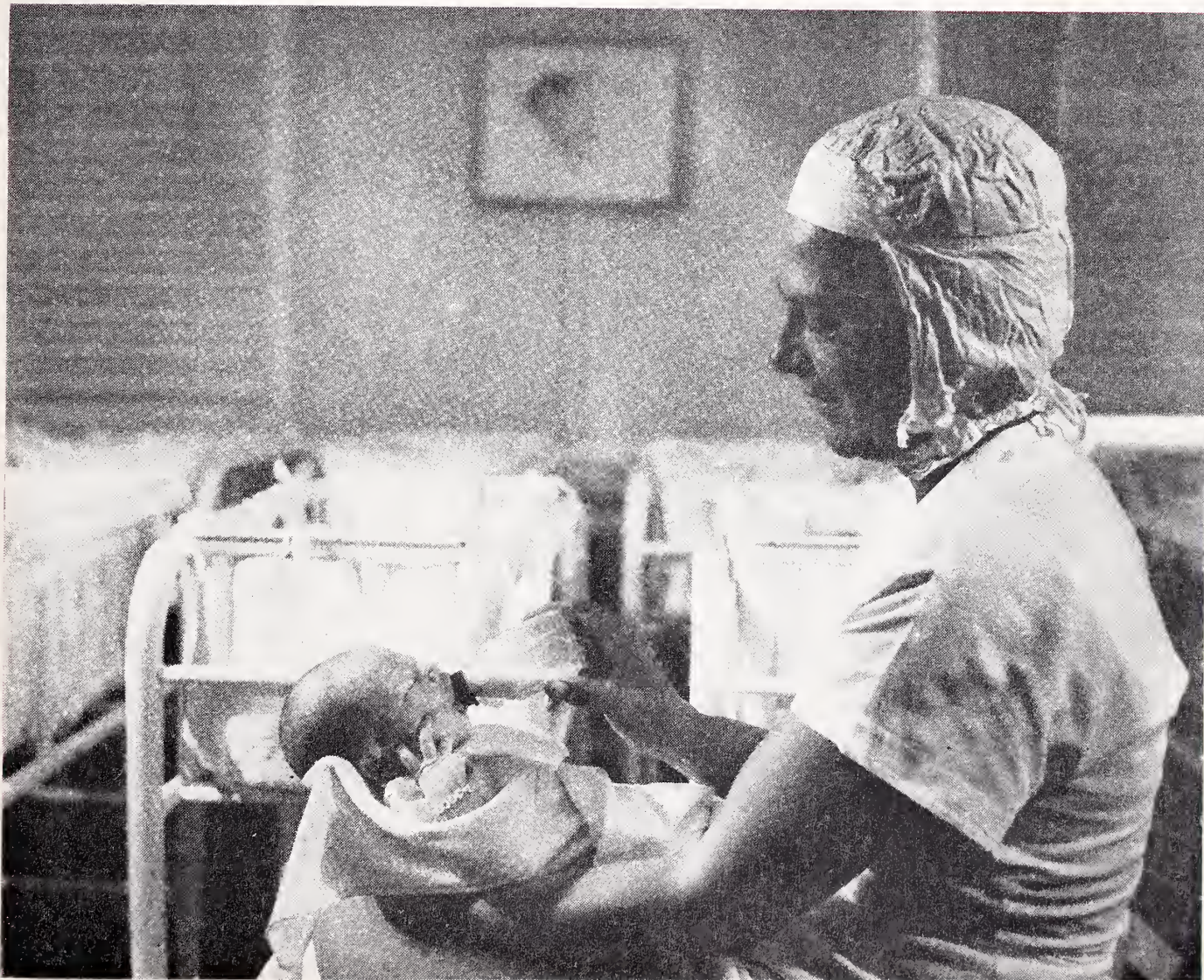
NEVILLE: *John C. Neville*, 80, of Register, died in the Bulloch Hospital June 23 from injuries received

in an auto accident several days previous to his death. Since his graduation from the Medical College of Georgia in 1900, he had practiced medicine in Bulloch County.

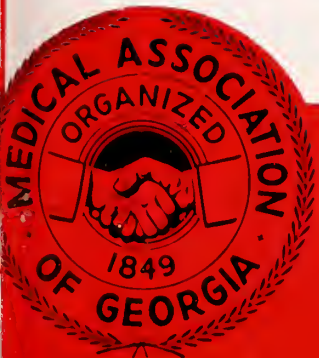
PATTON: *Lewis N. Patton*, 57, of Athens, died as a result of a automobile accident which occurred six miles south of Elberton. He died in an Elberton Hospital June 24. He was a graduate of Emory University School of Medicine, 1923, and had practiced medicine in Athens for 20 years as an eye, ear, nose and throat specialist.

JOURNAL of The Medical Association of Georgia

AUGUST • 1953

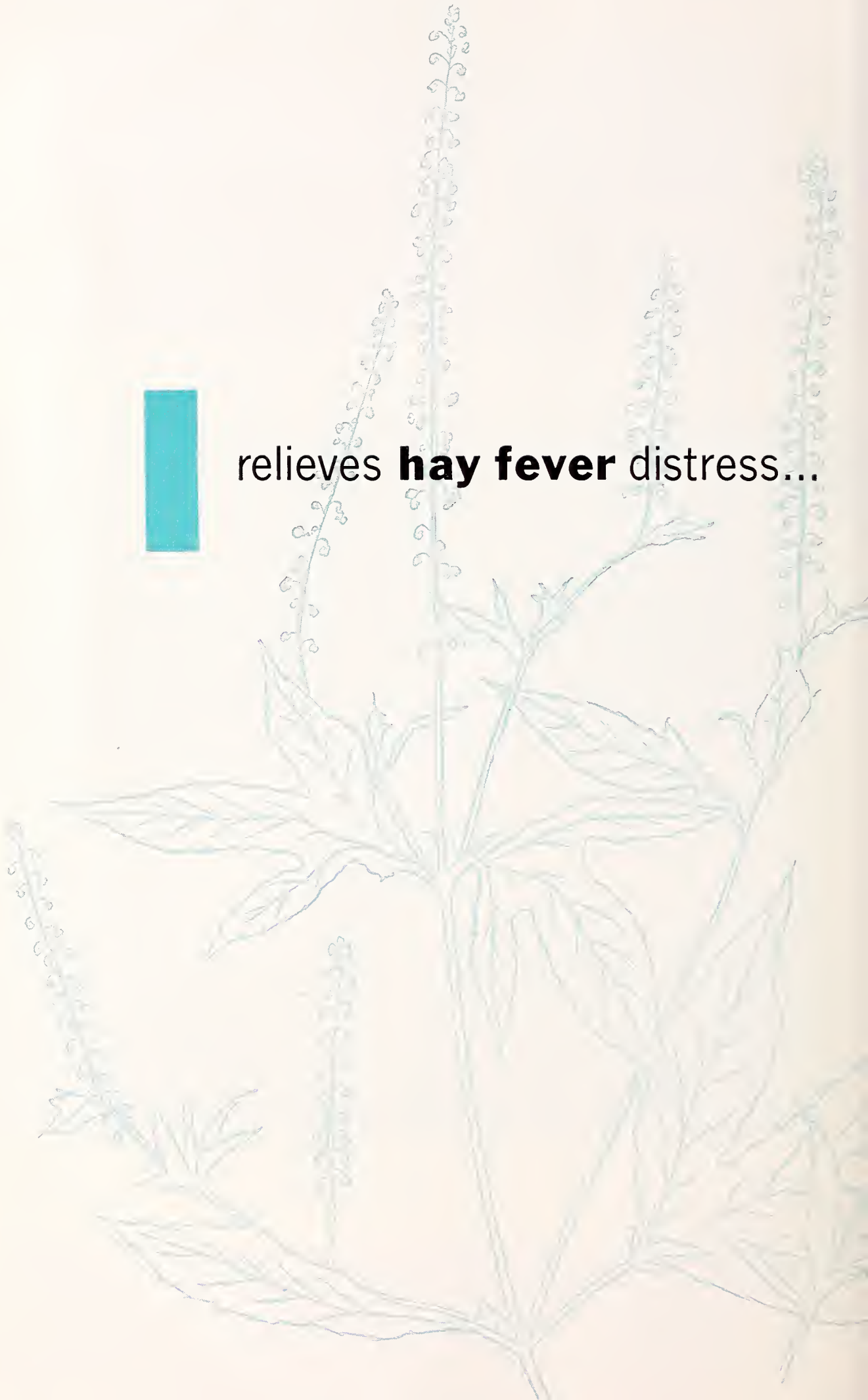


CARE OF THE NEWBORN — See Page 369





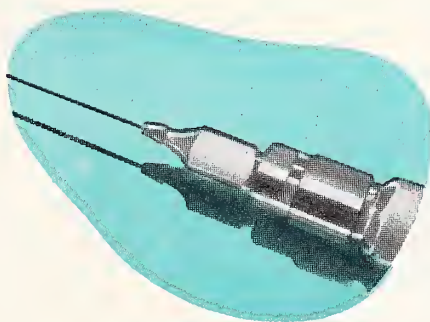
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AUGUST, 1953

VOLUME 42 NUMBER 8



Photo by Ted F. Leigh, M.D.

In calling your attention to the lead article "Some Problems in the Care of the Newborn" by Heyworth N. Sanford, the brighter side is depicted in the cover picture. An editorial also highlighting this paper appears in the Editorial section.

Another paper, "Investing in Stocks and Bonds" by Jack F. Glenn, Assistant President of the Citizens and Southern Bank, Atlanta, which runs in the Special Article section, merits your reading. This work is part of a series on medical economics.

The staff of the *Journal* also wishes to thank the many secretaries of the District and County Medical Societies who responded to the meeting data query sheet. Their response has helped make the announcement section of the *Journal* a complete list of Association meetings from month to month.

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president's page

A pleasure that it is possible for each of us to have is the professional respect and personal confidence of our fellow practitioners. If, in your daily contact with colleagues, you lay the foundation for this achievement, you will be rewarded by having the admiration of those with whom you have worked.

There is no justification for derogatory comments about another physician based on professional jealousy. If necessary, criticism should be given in a helpful and constructive manner. Always be available to help a physician who really needs your assistance. When called in consultation give the patient the benefit of your advice without any reflection on previous service rendered. If encouraged by a patient to be critical of another doctor, handle this situation as you would want it done if you were the one toward whom the finger was being pointed. Welcome a frank discussion of problems of mutual concern. If a patient tells you of some unkind remark made about you by another doctor, do not take this seriously; it may not be true. Many of our misunderstandings can be avoided if opinions are based on facts and not hearsay.

Adherence to these principles will cement friendships that will be cherished and add to your happiness in years to come.

William Harbin

The JOURNAL of the Medical Association of Georgia

MAKE YOUR RESERVATIONS FOR THE 1954 ANNUAL SESSION IN MACON MAY 2 - 5, 1954

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STATEMENT OF EDITORIAL POLICY

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editor's mail

To the Editor:

Recently a so-called 3-D Dinner (doctors, dentists and druggists) was held at Savannah under the sponsorship of the Savannah Pharmaceutical Association with some 103 doctors, 30 dentists and 67 druggists in attendance. This is the first of what we hope will be a series of these meetings over the State to stimulate interprofessional relations.

During the meeting a picture was made showing Drs. C. F. Holton, immediate past president of the Medical Association; S. Eisenberg, former president, Georgia Dental Association; Ralph W. Burton, president, Savannah Pharmaceutical Ass'n.; and Cliff Davenport, executive director, Savannah Chamber of Commerce.

Sincerely yours,
FELTON H. GORDON, Secretary
Georgia Pharmaceutical Ass'n.



Shown here are, left to right, Cliff Davenport, executive director, Savannah Chamber of Commerce; Dr. C. F. Holton, immediate past president of the Medical Association of Georgia; Ralph W. Burton, president of the host group; and Dr. S. Eisenberg, former president of the Georgia Dental Association and now head of the Southeastern District Dental Association.

To the Editor:

It is still difficult for me to find the mailing address in our *Journal*.

I don't know the proper and ethical manner in which to state in our *Journal* the fact that I am willing with very little persuasion to retire from my practice. I have a nice building owned by we three doctors where I have practiced since 1920.

We have an unusually nice, attractive town for young people. We have among the other doctors one other man limiting his practice to E. E. N. & T. He tells me he would welcome a nice clean young man locating here. I had hoped to continue a limited practice but it seems as fate deems otherwise. I have been out of my office since January, 1953. Now I am again faced with several more months in bed, salt free diet and everything else to take the pleasure out of life.

There is a lady—widow of one of my classmates—who operates a Placement Bureau for doctors. I had one or two lively looking prospects from her office but they all wanted to live in the city, and have a guarantee of income, etc.

Whether I sell my building or not, Thomasville still remains a good location for a qualified E. E. N. & T. man. If you hear of such a person send him to see me and I will be happy to show him around with no obligation. (And to repeat, confidentially where do you find the Association address in the *Journal*?)

Sincerely,
HENRY M. MOORE, M.D.

Editor's Note: Since receiving Dr. Moore's letter we have placed the *Journal* address in a more prominent spot on the Contents Page.

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PROBLEMS *and* SOLUTIONS

"I am informed by philologists that the 'rise of power' of these two words, 'problem' and 'solution' as the dominant terms of public debate, is an affair of the last two centuries and especially of the nineteenth. Having synchronized, so they say, with the parallel 'rise of power' of the word 'Happiness' . . . Like happiness, our two terms 'Problems' and 'solutions' are not to be found in the Bible—a point which gives to that wonderful literature a singular charm and cogency . . . On the whole, the influence of these words is malign and becomes increasingly so. They have deluded poor men with Messianic expectations . . . which are fatal to steadfast persistence in good workmanship and to well-doing in general."

L. P. Jacks: Stephenson Lectures, 1926-27

The comfort and serenity of our living is more and more being disturbed by the intrusion of that forceful and authoritative creature who, pointing the accusing finger at us from the television screen, tells us of our "problems"—soap "problems", body odor "problems", constipation "problems"—and then immediately "solves" these 'problems' with this or that brand or method or gadget. To the average person who has been told he lives in a scientific age, life presents itself much in this manner, as a series of "problems" for which he has only to find the "solution" and happiness will be the inevitable result. Both physician and patient seem to have fallen under the spell of this analytical approach to phenomena and are distressed to find that the more he uses these

things at his disposal (soaps, deodorants, cathartics, new and sensational drugs, machines, etc.) the more his "problem" increases in hardness and complexity.

There appears to be among physicians a growing tendency to rationalize the ills of mankind along the lines of "detective story" fiction and "the television-crime-opera."

Both physicians and patients seem to be fascinated with the notion that within "dis-ease", there is a "problem", that somehow has a "solution", which, if it can be found, will result in a "cure." To that end, the physician probes the victim's body with X-rays and examines blood and secretions with chemicals in the scientific search for the offender in order to dispose of it with drugs and thus end the story with a *Fait Accompli*.

Yet the common man, constantly hearing and reading about his health and disease in this scientific era, clearly has been made to believe (often by the physician himself) that there is a magic formula for all diseases. If this formula can only be found!

"Hear, you," he will cry, laying hold of the physician, "You have some magic formula that will unlock this problem; apply it to us. Give us the solution to our health."

How much of treatments of "dis-ease" and the articles in our medical journals are the frustrating attempts to answer this demand? When will we learn to abandon the conception of mastery over life and to cooperate with it in love? Remember the saying of the prophets, "Whosoever shall be Lord of life, let him first be its servant."

How RICH Are Your RELATIONS?

Public Relations in its simplest form means only the opinion that others have of you and what you have to sell. Public Relations are with us at all times. They may be good or bad, rich or poor. Nevertheless, they exist and cannot be ignored. Just how effective these public relations can be depends primarily upon the individual, but each

individual physician can do much more if he has some help and assistance from his local and state medical societies.

Back in the golden era of bootleggers, gangsters and ready money, everyone felt rich. The doctors had very little difficulty collecting bills and the people looked upon the doctor as a friend. When hard

times came these same people forgot that the doctor, too, had to eat and pay his bills. So during the last 20 years, the doctor has become, to some, an ogre who has no purpose in life except to squeeze the last penny out of his patients. Mr. Ewing and the last presidential administration did not do anything to change this opinion and gradually the breach between doctor and patient widened. This was the era of poorest public relations, and it was not until threatened with socialized medicine that the average physician even realized there was a threat to his independence. Suddenly the medical profession became imbued with the spirit of self righteousness and a desire to crusade against socialized medicine, and to tell the people how they would suffer if it ever did come to pass.

With a threat of socialized medicine temporarily side-tracked, we cannot afford to sit back in a well upholstered chair and relax. It is now, more than any time in the recent past, that we can "make friends and influence people." The proof of this was recently shown in *LIFE* magazine (June 22, 1953) when, during a tirade against the House of Delegates of the American Medical Association, *LIFE* reported "Many local AMA organizations behave in a far more mature way than their House of Delegates. Recently in Atlanta, the County Medical Organization showed that it knew how to make friends for its profession. Collaborating with the *Atlanta Journal*, some 80 doctors donated time to conduct a nine week public Forum in a downtown theatre, explaining health problems and giving free advice. The Forum

played to over-flow audiences and was such a success that it is now being continued once a week on TV." This little item points the way as clearly as anything possibly could. Let's not waste too much time in getting started.

Public Relations cost money. When you take a friend to dinner or to a show, you know that you are gaining his good will and do not hesitate to weigh the cost in terms of dollars and cents. Probably a great majority of you smoke. You do not hesitate to put down 25 cents or more each and every morning of the week for cigarettes, cigars or some personal comfort of this nature. In order to protect your personal comforts then, wouldn't it be worth at least the price of a package of cigarettes *once* a week to maintain the security of private practice and build the good will of the people in your community? Your medical association has not appropriated funds specifically for public relations this year because our state levies one of the lowest dues in the entire country. So, therefore, we must ask help until such necessary financial measures as are incorporated in future budgets can be made available for public relations. It is YOUR public relations committee, YOUR medical association, YOUR county organization, and it is YOUR practice of medicine that we are all working toward. Let's support it by at least the price of a package of cigarettes each week. Twenty-five cents a week for 52 weeks means \$13, and this much contributed by each member of the organization will help us to do the tremendous job we have undertaken for the coming year.

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Georgia PEDIATRICIANS, GPs *and* OBSTETRICIANS--

Your ATTENTION *Please!*

Seldom does the *Journal* ever consider it timely or even in good taste to call attention to any one particular article that it publishes, but the exception is included in this issue. Heyworth N. Sanford, M.D., Professor of Pediatrics at the University of Illinois has presented a most important contribution when he considered the various causes of death in the newborn (first two weeks of life). He begins this exhaustive study by pointing up the highly significant fact that there has been practically no

worthwhile reduction in newborn and early infancy morality over many years.

The situation in Georgia will be presented as part of a study to be carried out by the Committee on Maternal Welfare of the Medical Association of Georgia, chairmaned by Dr. Peter Hydrick, of College Park.

All physicians will be asked to cooperate—by submitting your experiences, results and recommendations in regard to improvements and therapy.

The GEORGIA DOCTOR *and the* DRAFT

Robert McKee, writing in the Sunday *Atlanta Journal and Constitution* of August 2 calls to the attention of all young male Georgians who have had no previous military service the somber fact that “the truce in Korea has removed the dread of being sent to active battlefronts, but the draft lives on.” According to Hershey, national selective service director, fathers will be drafted after August 25, and 19-year-olds are being taken now.

This of course means that the need for doctors, nurses and other medical personnel remains as high as before. The seriousness of the situation is indi-

cated by the passage of the second Doctors Draft Law on June 29 by both houses of Congress without significant opposition. Fortunately, this bill is more liberal in some respects than the first one, and corrects many of the inequities and unfair requirements that existed in the earlier law.

How this situation affects the young doctors in Georgia, including some in Priority I who received all or part of their education at the expense of their government (or were deferred for this purpose) and who have not served their country in any capacity, is of course a matter of concern to all doctors in the State. Fortunately, no serious shortage has result-

ed nor have any communities suffered by the temporary loss of the 198 physicians who have gone into military service up to now. Replacements in the affected communities have been fairly easy to obtain on both temporary and permanent basis and no medical hardships are known to exist. Highly commendable is the fact that it has not been necessary to draft a single Georgia doctor into the service as an enlisted man.

Much of the success of the management of the doctor draft law in Georgia rightly goes to the local draft boards which have followed recommendations of the Medical Military Advisory Committee, chaired by Dr. A. O. Linch of Atlanta. The House of Delegates of the MAG took cognizance of this fact recently by expressing appreciation to these officials of the Draft Boards, knowing how difficult a task it had been to send into service their doctor who was also their friend.

However excellent that record may seem, unfortunately it is marred by the fact that there are eligible, unessential, and physically fit doctors in Georgia, who are in Priority I and up to now have given no service to their country. Such cases have been reviewed repeatedly by the Medical Military Advisory Committee which has striven to be fair to these individuals; but decision, nevertheless, must be made on fact and not sentiment. Proper consideration has

been given to many petitions and appeals from patients and interested citizens in communities, but it is generally known that such can be prompted by the affected individual and that essentiality is self-evident and needs no defense. Also little, if any, attention can be given to such excuses as "he is the only doctor who will make night calls," or "he makes low charges for poor people." If such were acceptable, all eligible doctors could easily supply such excuses to evade the draft, and the entire program would become inoperative throughout the country. That never has and never will happen in this country.

These men have not been required to answer the call of their country because their local draft boards have chosen to consider them essential and to disregard the recommendations of the advisory committee of fellow doctors established for that purpose. This decision on the part of a few draft boards apparently has not been challenged by the State Selective Service Board, and until now, none of the cases has been referred to an Appeal Board, all of which were set up for such purpose. The Committee is hopeful that a request made recently to transfer such cases to the Appeal Boards will be followed promptly.

Already, older doctors (Priority III) are being processed and called up for service and more will be needed. The Committee finds it difficult to declare any of these men available and unessential as long as the younger men remain securely at home.

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HEYWORTH N. SANFORD, M.D., Chicago

*Some Problems in*CARE *of the* NEWBORN

In our Chicago area during the ten-year-period from 1939 to 1949, infant mortality has been lowered approximately 10 per cent. This saving in infant lives has been accomplished principally in the group representing the latter half of the first year of life. Unfortunately, this reduction does not extend into the newborn period. During the same interval of time the mortality for the first two weeks of life has only been reduced approximately three per cent. This failure to reduce the newborn mortality in the proportions as shown by older infants is reflected similarly throughout the United States as a whole. From 1948 to 1953, the next five-year-period, the neo-natal mortality in Chicago has been lowered 1.3 per cent.

Obviously to further reduce neo-natal mortality, it is necessary to have an understanding of its various causes. In the excellent study made by Bundesen¹ et al, it was found that excluding prematurity, which will be taken up separately, that the greatest cause of death in the newborn period was due to respiratory disturbances, or abnormal pulmonary ventilation. This accounted for 54.3 per cent or over one-half the causes of death in the first day of life. The second greatest cause was injuries at birth 18.2 per cent, and the third was congenital malformations or 12.0 per cent. These three conditions accounted for 84 per cent of the total mortality for the first day of life. Of the remainder, infections were 6.2 per cent, anoxia was 4.7 per cent and blood dyscrasias were 3.9 per cent.

This proportion is only for the first day of life. As the infant grows older the picture changes. To the end of the first month of life, abnormal pulmonary ventilation falls to 31.9 per cent, while infection rises to 21.5 per cent and further increases, until during the next 11 months it totals 53.6 per cent of the total mortality.

We often speak of the first day of a person's life as being the most dangerous time for their existence. This is exemplified by the fact that the total mortality for the first day of life was 35.8 per cent, while the mortality for the next 29 days was 33.7 per cent, and for the next 11 months was 30.5 per cent.

Our first problem, therefore, with the newborn

is to obtain proper breathing. This emphasizes gentleness and the usual procedures necessary for the majority of newborn. However, certain pathological factors may exist that make these procedures insufficient. The two most frequent are atelectasis and pulmonary hyaline membrane.

Atelectasis is usually a diffuse process or a combination of atelectasis and emphysema, as factors favorable to air trapping may lead to interstitial emphysema, pneumomediastinum, and pneumothorax. Occasionally, this atelectasis may be localized to one or two lobes from the obstruction of a large bronchus. In this case, bronchoscopic aspiration will give immediate relief. This condition should always be suspected in all instances of cyanosis of the newborn, occurring at once or shortly after birth. It is necessary to rule out other causes of cyanosis, such as congenital heart disease, intracranial hemorrhage, pulmonary infection, tracheo-bronchial fistula, diaphragmatic hernia, and adrenal hemorrhage. This may be easily accomplished by a roentgenogram of the chest, and is obvious if the fluoroscope indicates a lung density. We have made it a practice to fluoroscope all newborn infants immediately after birth, and if such a condition exists a bronchoscopist is called at once into consultation. The method used is that of inserting an infant-size bronchoscope as suggested by House and Owen.⁵ Even if only the main bronchus leading to the lobe is cleared, spontaneous drainage will follow in 24 to 48 hours.

It is useless to use this method if the atelectasis is scattered over the lung area, or if more than a single lobe is involved. In these instances we must resort to oxygen alone, or use some form of mechanical resuscitation. Bloxom's Oxygen Air Lock was devised for this purpose. The infant is placed in an atmosphere of 60 per cent oxygen concentration and the chamber locked. The pressure is then raised to three pounds per square inch and lowered automatically to one pound. It is assumed that oxygen under pressure is better absorbed through the skin and mucous membranes, that by expansion of gases, amniotic fluid and secretion are forced from the air passages, and the infant is better conditioned for normal respiratory activity. Whether this is true or not can only be found by many trials in various hospitals.

Pulmonary hyaline membrane is a major factor in deaths from respiratory causes in the newborn period. The chief damage appears to be from plugging the alveolar ducts and producing secondary or resorption atelectasis. It is found most often in premature infants, and those full term infants that are

*From the Department of Pediatrics, University of Illinois, College of Medicine, 1953 W. Polk Street, and Presbyterian Hospital, 1753 W. Congress Street, Chicago 12, Illinois.

Read before the Section on Pediatrics, 103rd Annual Session of the Medical Association of Georgia, Savannah, May 11, 1953.

born by Caesarian section and those associated with prenatal and natal anoxia. Analysis shows it to be of protein material, while vernix is not a constant component. It may originate from amniotic fluid, and air breathing seems to be essential for its formation, as it is not found in still born infants or in those dying within one hour after birth. Miller⁹ believes that it is a protein exudate from injured tissues of the bronchioles and alveoli.

The symptoms begin two to three hours after birth, following normal breathing, with dyspnea, retractions of the costal margins and lower sternum, and grunting, followed by cyanosis. Death occurs within a few hours after onset in many instances, while in others the condition persists for two to four days with recovery.

A new approach to this problem of pulmonary hyaline membrane and scattered atelectasis was first shown by Miller.¹⁰ In this a humidified atmosphere was advocated for the newborn infant, which contained a material that acted directly on the substances blocking the airways. This was first noted by the sputum-liquifying action of aerosols in adults treated for pulmonary tuberculosis. The detergent that we have been using is "Alevaire" or Triton WR 1339, which is 0.125 per cent in combination with sodium bicarbonate 2 per cent, and glycerine 5 per cent. This is administered in the apparatus as outlined by Ravenal,¹³ consisting of a nebulizer attached to an oxygen tank. The vapor is delivered directly into a croup tent or incubator.

Ravenal¹³ has reported a series of 18 infants who presented signs of atelectasis or fluid respiration. Eight of these were premature and in six the diagnosis was confirmed by roentgenogram. All of these infants recovered. He advocates that this aerosol should be employed prophylactically after obstetric complications that entail the possibility of respiratory difficulties from aspiration of fluid into lungs or after regurgitation of food causing asphyxia. Also, in all premature babies, those born by Caesarian section, those with respiratory difficulties, and those that have aspirated milk into the lungs. In addition, penicillin and streptomycin should be administered for three to four days to the last groups and to those born after a prolonged or dry labor.

We have adopted these measures and have been using aerosol for the last three months. It is easy to administer, and does not seem to have any injurious effects. It has not been in use long enough to make any definite statements as to its efficacy, but our impression is that it is helpful. However, some deaths have resulted from massive atelectasis, showing that it is not the complete answer to this condition, but it certainly offers at least a sensible method of approach.

Infants born by Caesarian section present another serious problem. Here the conditioning to normal respiratory function by passage through the birth canal is lacking. It has been noted that there is an excessive quantity of amniotic fluid in the respiratory tract and stomach. Potter¹² has also noted that at autopsy there was a marked edema of the men-

inges, and that hyaline membrane was found with greater frequency. Gellis³ has proposed that aspiration of the fluid from the stomach should be done immediately after birth. This lessens the possibility of regurgitation of stomach contents and aspiration into the lungs. It has also been suggested that fluids should be restricted in these infants for several days because of their tendency to edema.

Injuries at birth is given as the second largest cause of newborn mortality, but it is doubtful if these are properly classified. A great many of these have other conditions or anomalies of the fetus as the actual background. Fortunately, we have about abandoned the old idea that it is always caused by indifferent obstetrics. The diagnosis of cerebral hemorrhage is not easy, and with our present day frequency of autopsies it is found that many that are given this clinical diagnosis are in fact due to some other etiological factor. I believe that to make a clinical diagnosis it is necessary for the baby to show: (1) cyanosis, (2) convulsions and (3) spasticity or flaccidity. Spinal punctures are of doubtful value even in diagnosis as the finding of red blood cells is not uncommon in the normal newborn. The treatment consists of absolute rest, a minimum of handling, elevation of the head, and an easy well digested food. Vitamin K is of doubtful value, although given by many hospitals. The value of repeated spinal taps in the treatment of intracranial hemorrhage is still controversial. Temporary relief of symptoms can be obtained in some instances, but whether this results in any beneficial effects that are of lasting value is open to question.¹¹

The importance of subdural hematomas is becoming more widely recognized. While the symptoms are not usually recognizable in the newborn period, any child that does not gain satisfactorily, or takes food poorly, and shows any evidence of intracranial pressure should be considered in this category. There is no harm in an exploratory spinal tap, which is easily done and the withdrawal of any residual hemorrhage may be life-saving.

The third greatest cause of new born mortality are congenital defects. These may be approached from the prophylactic standpoint in a study of prenatal environment, and from a postnatal standpoint by possible correction. In the prenatal period the health of the mother is of prime importance. Gregg⁴ has demonstrated that rubella in the first trimester of pregnancy will in a high percentage of instances result in malformation of the offspring, resulting in cataracts, heart disease, and mental deficiency. War-kany¹⁵ showed that rats deficient in riboflavin had skeletal deformities, as cleft palate, syndactylism, and shortening of the bones. When vitamin A was deficient, malformations of the soft tissues of the eyes, heart, and kidneys occurred. Ingals⁶ has produced anencephaly, and cleft palate by maternal anoxia. This depends on the degree of anoxia and the stage of gestation at which it occurs.

This implies from a practical standpoint that some congenital anomalies are not beyond the possibility of control, and that the suspicion of hereditary taint can be removed from the parents, and emphasize the vital relationship between the mother's health

and the development of the offspring.

It has long been known that fetal health was disturbed by maternal disease. The status of babies born of diabetic mothers is of interest. This is recent, as control of diabetes now makes child bearing possible. There is a high mortality in these infants. They show higher than average birth weight, probably due to maternal hyperglycemia, a higher erythroblast count than normal in the circulating blood, and at autopsy extramedullary centers of hemopoiesis in the liver and spleen, with an enlarged heart. Miller⁸ has shown statistically that the mother may not be diabetic at the time of delivery but was pre-diabetic, and developed diabetes later. These infants may be helped prenatally by adequate control of the diabetes, and the possible administration of estrogens and prenatal oxygen after delivery with restriction of fluids in the first two days, and the possible administration of glucose and epinephrine to prevent hypoglycemia at birth.

Jaudon⁷ has described a clinical syndrome which he believes due to temporary adrenocortical insufficiency in the neonatal and early infancy period. This is characterized by vomiting, failure to gain weight, and severe dehydration. There is an accompanying low serum chloride level, low sodium, and often elevated potassium levels. This condition is found with some frequency if the syndrome is kept in mind. It is corrected by the administration of desoxycorticosterone acetate, and increasing the intake of sodium chloride. It is frequently mistaken for pyloric stenosis.

Congenital anomalies are found most often to be within the heart, nervous system, and gastro-intestinal tract. While congenital defects of the heart do not lend themselves to diagnosis in the newborn period there are three conditions that should be considered. If diagnosis is possible, the sooner attempts are made for correction the better. The first is double aortic arch. Here the trachea and esophagus are encircled by a vascular ring. The symptoms are stridor, which comes on in the first day of life, a barking metallic cough, and difficulty in swallowing. A barium swallow reveals under the fluoroscope a narrowing of the esophagus at the level of the aortic arch, and indentation of the posterior surface of the esophagus in the lateral view. The symptoms are alarming and often fatal. The operation consists of severing the smaller portion of the arch.

The second is infantile type of coarction of the aorta. Here the aorta is narrowed from the origin of the left subclavian to the insertion of the ductus arteriosus. If there is cyanosis usually from some other anomaly, the condition may be suspected. Unfortunately, the femoral arteries may be palpated in some instances. The blood pressure in the upper extremities, however, is high, while very low in the lower extremities. Calodney and Carson² diagnosed 14 of 22 instances of this condition. If the diagnosis can be made, operation is indicated at once, as the condition is not compatible with life, after the closure of the ductus. This may take place at any time. As

yet, no successful operations have been performed in this institution on any of these children, but I believe that it can be done.

The third is tricuspid atresia or stenosis. The type amenable to surgery consists of the above plus interauricular communication, hypoplasia of the right ventricle, an atresia of the pulmonary artery, and a patent ductus, or interventricular septal defect. These children always have cyanosis, systolic murmur, large left ventricle shown by roentgenogram, and left axis deviation by the electrocardiogram. We have had several such infants survive operation at the end of the newborn period. This should be attempted as the condition is not compatible with any long life span.

Anomalies of the gastro-intestinal tract have the two cardinal symptoms of vomiting, and absence of the stool, or a change in normal color. Esophaghal vomiting indicates an atresia of the esophagus or a tracheo-bronchial fistula. An immediate overflowing of saliva, with constant drooling and respiratory difficulty results. Lipiodal will show the constriction and immediate surgical repair may be possible.

Pyloric or duodenal vomiting due to obstruction at either of these levels of the small intestine is explosive, and contains stomach contents. Obstruction at a still lower level, either of the small intestine or large, may be delayed in its onset, but is usually preceded by distension at the point of atresia. Here the vomiting is fecal.

If the obstruction is above the ampulla, the stools will be normal meconium. If it is below the ampulla, they will be grey, white and mucoid. The greatest help in the early diagnosis of these conditions has been made by the studies of Wasch and Marck.¹⁶ In roentgenographic studies of normal newborn, they found that air is present in the stomach at birth. Between the first and third hour the small bowel is filled, by the eighth hour closely packed segments of the small bowel fill the abdominal cavity, and at the end of the twelfth hour the normal pattern is established. This makes a contrast medium unnecessary, and is much safer for the infant. Early operation may now be successfully accomplished, and is life-saving. In the last month we operated on an infant with volvulus of the small bowel at 20 hours of life, with success, although a meconium ileus made resection of a portion of the bowel necessary. Needless to say, the newborn must be placed in good condition for the surgical procedure, by transfusions, and adequate water and electrolyte balance.

The three conditions, respiratory disturbances, injuries at birth, and congenital defects account for four-fifths of all the mortality of the newborn period. While the remainder are not so frequent, they can still be reduced, and further decrease the causes of death for this group. The largest of these is infection, which causes 6.2 per cent of the total mortality. It is important to diagnose these at once, as prompt treatment offers a considerable betterment of the prognosis. Better nursery technique has so decreased infections that they are not

now considered as soon as they should be.

They should be suspected in every obscure illness during the newborn period. It is often stated that they occur later in the newborn period but a study by Silverman and Homan¹⁴ showed that 25 per cent occurred in the period from one to five days of life, 25 per cent in the third day to the seventh, and 20 five per cent in the fifth to tenth day.

There are three clinical signs that may lead us to suspect the condition. These are fever over 101°, respiratory difficulty, and jaundice. Also, about one-third will show gastro-intestinal disturbances. Of the above signs, jaundice is the most helpful from a differential basis. This must be differentiated from physiological jaundice, hemolytic jaundice, and obstructive jaundice from biliary tract pathology, which occurs late in the newborn period. If the condition is suspected, a blood culture, umbilical culture, urine culture, and spinal fluid examination should be done.

If infection is at all suspected, there is no harm in the administration of some form of antibiotic immediately, then changing if necessary when the actual organism is cultured. Newborns tolerate any form of antibiotic very well. Perhaps the best and easiest to administer is 150,000 units of repository penicillin daily. The antagonists to the common organisms affecting the newborn are *B. coli*, penicillin, sulfadiazine, and aureomycin. *S. hemolyticus* are penicillin, sulfadiazine, and aureomycin. *Staphylococcus* are penicillin and aureomycin. *H. Influenza*, is streptomycin. The latter may be given 125,000 U. intramuscularly every six hours, or 88,000 U. by mouth every four hours. Aureomycin may also be given by mouth in amounts of 10 to 20 mg. per pound. It is active for both gram negative and positive organisms, as well as virus infections.

Lastly, blood dyscrasias occur which cause 3.9 per cent of the total mortality. Hemorrhagic manifestations and hemorrhagic disease are not synonymous. Ten per cent of normal newborns will show some hemorrhagic manifestations which do not require any therapy. True hemorrhagic disease is uncommon. It is usually not at all due to prothrombin deficiency, but to infections. Vitamin K is usually given, but while this does no harm, it will not cure the actual cause. The treatment should be blood transfusions and antibiotics for the infection.

Hemolytic disease of the newborn has been discussed so much in the recent literature that very little need to be said about it. The ultimate solution lies in the hands of the obstetricians in finding some method of rendering the antibodies formed by the mother ineffective. We have been using Hapten R with some success if given before the fifth month of fetal life. Other groups have reported some success with ACTH. Neither of these are reliable, however, in all instances. At present the important thing is that any Rh- mother who develops antibodies during pregnancy should be delivered in a hospital where the greatest care of the newborn can be given. If such a baby is born with nucleated red cells in the cord blood of over 10 per cent, with a hemoglobin less than 13 grams, or a positive Coombs' test, it should be considered as suffering from hemolytic dis-

ease until proven otherwise.

In the actual treatment, transfusions, oxygen, and antibiotics still are the accepted method. We have failed to see any great difference between replacement transfusions, and ordinary transfusions that keep the blood at a level of 13 grams hemoglobin and over 4,000,000 red cells. We are at present only giving replacement transfusions to those babies born jaundiced or edematous.

In studying mortality statistics in Chicago, we have found that many babies that are transported to another hospital for replacement transfusions die. The pediatrician will find that he has done more for the child if he gives an immediate transfusion of the proper type blood as soon after delivery as possible, than in wasting time in setting up for a replacement transfusion if not immediately available, or transporting them to some hospital thus delaying such form of therapy. He will not be neglecting the baby by such a procedure, but may save a life.

This summarizes the principal conditions that endanger the life of the newborn. An attempt has been made to indicate what observations and autopsy studies have shown to be the main conditions from which the newborn may suffer in its first days of life. What seems to be significant trends have been indicated. All whose interests have been in this field of pediatrics are particularly pleased by the attention that is being given to the newborn by all physicians. It is in this period of life that an individual is in the greatest danger, and such interest as has been shown in the past few years can only indicate a more hopeful outlook for that period which has been identified by C. A. Smith as "The Valley of the Shadow of Birth."

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An industrialist has said of his company, "Our primary purpose is to create that which the world can use to advantage, to produce it and distribute it at a cost that permits of a selling price that the market can afford to pay and still leave to the stockholders and the employees a fair return for their effort. Every activity which we undertake must be measured, in the final analysis, by an economic yardstick. Our experience has never shown any conflict whatever between the profit motive and the fair, honest and frank treatment of the problems arising from our employee relationship."

If the art and science of medicine is to make its optimal contribution to the well-being of the men and women in industry, the physician, I feel, must examine the question: How does my work assist the aims of the productive unit—the plant team?

To meet the operational responsibilities of a medical department in industry, the physician must accept wholeheartedly and constantly keep in mind the primary purpose of industry. It may seem trite to labor the point. Yet, problems which plague a physician in industry arise frequently enough from the oversight of industry's primary purpose as to warrant emphasis.

Industry functions with operating departments as the central structure, with auxiliary or service departments attached as they are required or prove themselves to be useful. Such auxiliary departments are exemplified by the legal department, the personnel department, research and exploration departments, advertising, safety, traffic, engineering groups, etcetera. The medical department in industry is such an auxiliary department. The medical department does not keep a profit and loss balance sheet; it does not manufacture or sell goods. It can justify its existence only through service to departments which do manufacture and sell. Its service must, in the final analysis, help operating departments in their job of manufacturing and selling at a profit.

There are two approaches to the exercise of the operational responsibilities of a physician who serves industry. One is through plant environment, the other is through the employee. In the environmental approach the physician needs to familiarize himself with raw materials used, manufacturing processes of his plant, its lighting, ventilation, sanitation and cleanliness, temperature and humidity, and other items which characterize its environment. In the approach through the employee the physician should help select the right man for the job and strive to keep that man fit for the job. The physician should know the principal physical and mental requirements of the job. He should have the judgment and initiative to utilize opportunities for putting this knowl-

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Operational Responsibilities of a MEDICAL Department in INDUSTRY

edge into effect. To reiterate, both the material side (industrial hygiene) and the human side (clinical medicine) must be considered in the physician's discharge of his operational responsibilities.

What are the steps whereby the service function of the industrial medical department is put into action?

(1) The physician in industry should maintain the proper professional relationship with the employee-patient. The health welfare of the employee is paramount to all other considerations of the physician. I believe that no medical department can carry out its operational responsibilities without holding firmly to this major premise. Whatever truly benefits the injured or ill worker enhances that worker's economic effectiveness as part of the industrial team. Whatever adversely affects the worker's health, either physically or mentally, reduces his effectiveness as a worker.

The industrial physician must respect the confidences of his patient, the worker, if maximum health service is to reach that worker. In private medical practice the patient selects a physician on the basis of confidence. Hence, in that relationship the treating physician starts with the confidence of the patient who comes to him voluntarily. On the other hand, the physician in industry must create confidence in the employee-patient as a first step to performing a professional service. The private patient may change his practitioner for personal medical care at will. The worker has no selection in the preventive medical program of a physician associated with an industrial organization. The obligation of the physician in industry to maintain good rapport with diverse worker personalities and the strain on the amenability of that physician is made greater by this necessary arrangement. The delicacy of human understanding involved here deserves much thought and careful planning.

(2) The physician in industry must accept sincerely his role as an organizer and as an adviser who is concerned chiefly with preventive medicine—the prevention of injury and disease within the confines of industry. This function requires special training

and knowledge (which varies from industry to industry), in addition to his medical training. In a chemical industry, for example, the physician needs to be, to some extent, a chemist and a toxicologist. As a chemist he needs to be able to recognize a host of biologically potent compounds ranging, shall we say, from possible carcinogenic agents to the industrial origin of odors which may linger on the female worker when she goes to a dance! Not only must he recognize the action of poisons already known but he must be able to detect new poisons which come into being as zealous research chemists modify and remake the environment of modern man.

The Chief Inspector of Factories in Great Britain in his annual report a few years ago said that the industrial medical officer should be as much as possible about the "works" and as little as possible in his factory ambulance room or surgery. The physician must keep in mind endless possible untoward reactions of workers to chemicals. He must be able to confer with engineers on dangerous industrial environmental conditions, problems of ventilation, lighting and heating, and the like. He must be executive enough to direct the work of nurses and laboratory technicians, to organize effective means of inspecting both the condition of the worker and the condition of the plant. Finally, he must be diplomat enough to understand and to deal with the varied viewpoints of managers and that of rank and file laborers. These factors have caused industrial medicine to become a specialty—one in which acquiring competence is difficult, yet highly rewarding.

(3) The physician in industry should have or know where to get the correct answer to questions passed to him by members of his organization. It is an operational responsibility that he be as dependable as is humanly possible in his opinions on medical matters. Changes affecting many people and occasionally even the survival of the business organization may depend at times on the decisions and recommendations of the medical department. A querulous, non-industrial patient may be given a "half-baked" or "brush off" answer and be happy with what he or she is told by his physician. I know this from experience in private practice! Let a physician in industry give a careless and inaccurate answer to a medical query and two things result but quickly:

(a) A penetrating, observing, non-medically trained mind in the organization spots the error, makes a private research project out of the matter and then confronts the physician with irrefutable and embarrassing facts.

(b) That physician acquires for himself a reputation for either sheer ignorance or unreliability because of indolence. Such is an undesirable reputation for the physician. Furthermore, that industry's operations are unfavorably affected because of widespread doubt regarding the validity of the medical adviser's recommendations. It is a poor industrial operation if someone must check regularly its medical department's decisions by contacting other medical sources.

(4) Industrial management expects from the medical department help in increasing the efficiency of

the employee on the job. High wage rates rest on high output. Operations depend on the men at the machines. Health and production are inter-dependent. To paraphrase the mission of the medical department of the U. S. Navy, the industrial medical department attempts "to keep as many men at as many machines as many working days as possible." This may be taken as an operational objective and to a great extent a responsibility of the medical department.

This is accomplished through such devices as placing the employee in a job which fits his abilities and experience; safeguarding the employee against health hazards; advising the employee in the correction of handicaps or deviations from health; and educating the employee regarding good living habits and the maintenance of optimal health.

(5) Another operational responsibility of the medical department is found in personal activities, in human relations, if you please. Numerous industries have found and have reported that an adequate industrial health service is an aid to sound employee-employer relations in the plant. A few years ago I asked a plant manager what he thought of his plant nurse. He replied, "She more than earns her salary by her non-medical, non-professional and non-clerical contributions to our organization. She's a fine morale builder. Men who have never needed her first aid ministrations know that she is here if they do need her. As a result these men are prouder of their plant and they say so. They lift their chins higher, wear cleaner clothes and work better than before our nurse came!"

Another plant manager had this to say of his plant medical director. "Our doctor is outstanding as a curiously successful personnel officer. His minor surgery and his medical examinations are good, I believe, but I think any one of hundreds of doctors could do as well on those things. What impresses me is the way the men on the plant like him. They believe in him, share their problems with him and invariably feel better after talking with him. He has their confidence. Even when he has to say 'No' he can make them like it! Things go smoother because he is part of our organization."

I suggest to you that the nurse and the doctor who earned these factual comments had a fine sense of operational responsibility.

(6) The medical department is responsible for proper investigation of its problems. There are many unsolved health problems affecting industrial personnel. Where knowledge required for their solution does not exist we must intensify our programs for research in preventive medicine. Much of this investigation can be done by the industrial medical department, utilizing (a) its recognition of the problem, (b) its proximity to it, and (c) its facilities to do something about it.

Dosing guinea pigs, rats and other laboratory animals has its place in medicine and I respect the laboratory for its past and continuing aid to the health of human beings. But the laboratory cannot do the job alone. In the industrial plants we have crucial health experiments going on each day—ex-

periments involving human beings. Significant information is there for those physicians who will have the patience to ferret it out. Industry looks to the physician to do this job of clinical investigation. The job is a continuing one.

(7) A word should be said on the desired personal characteristics of the physician in a medical department which meets its operational responsibilities. The ideal physician in plant operations must like men—both good and bad men. Undoubtedly he should enjoy being called “Doc!” He should have the warm streak of human sympathy which can draw him close to the workman who may garble his grammar and express himself obliquely, who even may have forgotten the distinction between right and wrong, who may curse the preacher and damn all men more fortunate than himself, but who still yells across the street with some sincerity, “Hi, Doc.” Such a man often feels that the doctor understands him better than do any others. Such a physician is that man’s promise for a better orientation in this complex world. In my opinion the doctor has a moral obligation to be ready and willing to help that man. This requires more than the technical knowledge of how to close a lacerated wound or read a blood pressure. This requires the patience of a good psychiatrist, the personal qualities of a diplomat, the trustworthiness of a father-confessor, the willingness to shoulder the impossible task of being all things to all men, the good sense to try, to fail and to try again.

Is this point of view an expression of maudlin sentimentality and idealistic foolishness in a materialistic

world? If you think so, I challenge you to go into plants where some of my confreres have served successfully for nearly a lifetime and find a better explanation for their results.

Were I to visit a strange plant and were assigned one hour in which to evaluate the effectiveness of the plant physician in meeting his operational responsibilities, how would I spend that hour? I would not bother to check the physician’s scholastic training, his records, his medical facilities, the results of his minor surgery or his therapy of patients made ill or injured by their work. I would not even need to interview the doctor. I would learn most during that hour by talking to men working in the plant, and from that experience I think I would come away with a surprisingly accurate evaluation of their plant physician.

In summary, let me point out that an industrial medical department is not a philanthropy. It came into being and continues to exist because the art and science of medicine has a contribution to make to the industrial process. This contribution has been found to be beneficial to the individual worker and in turn profitable to the operating departments. The medical department exerts its influence in an advisory capacity as a service or auxiliary department. Its opportunities are found in the man or woman who is the worker and in the plant physical environment. Its operational responsibilities call for an insight into preventive medicine, an understanding of industry’s functions and obligations, and the highest type of professional behavior.

Medical Student Prize

The Board of Regents of the American College of Chest Physicians offers three awards to be given annually for the best original contribution, prepared by any medical student studying for the degree of Doctor of Medicine, on any phase relating to the diagnosis and treatment of chest disease.

The first prize will consist of a cash award of \$250 and a certificate. The second and third prizes will be certificates of merit. The Essay award is open to all medical students in accredited medical schools throughout the world.

The winning contributions will be selected by a board of impartial judges and will be announced at the 20th Annual Meeting of the American College of Chest Physicians to be held in San Francisco, California, June 17-20, 1954. All manuscripts become the property of the American College of Chest Physicians and will be referred to the Editorial Board of the College journal *Diseases of the Chest* for consideration. The College reserves the right to invite the winner of the first prize to present his con-

tribution at the Annual Meeting.

Applicants are advised to study the format of *Diseases of the Chest* as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than March 15, 1954.

2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside enclosing the name and address of the author.

3. A letter from the Dean or Chairman of the Department of Medicine of the medical school certifying that the author is a medical student studying for the degree of Doctor of Medicine and that the contents represent original work.

vasion by the common organisms producing the vaginal infections. Hyperactivity of the cervical glands with an increased amount of alkaline secretion may increase the pH to as high as 6, and invasion by

LEUKORRHEA

WILLIAM C. HELMS, M.D., Atlanta

Leukorrhea may be defined as any abnormal blood-free discharge arising from the genital tract. Of all the complaints with which women confront the gynecologist this is the most common, occurring in at least one third of all gynecologic cases. Some patients under examination for other indications may have a profuse leukorrhea of which they make no complaint, while others with but a slight increase in the vaginal discharge may be quite upset by it. It should be remembered that leukorrhea is a symptom, not a disease, caused by a number of different pathologic entities.

Normally, the genital mucous membrane is kept in a moistened state by secretions arising in the cervical glands, Bartholin's glands, Skene's glands and the numerous sebaceous and sudoriferous glands of the vulva. Some of the secretion represents a transudate from the vaginal mucosa, but the endocervical glands are the chief source. These secretions are essential to a healthy vagina as the vagina has no glands of its own and in a relatively dry state would be prone to excoriations and infections. This condition is sometimes observed in women who are in the habit of douching several times daily, thereby removing the protective action of the normal vaginal mucus. Under normal circumstances the genital secretions do not escape to the outside, though most women, at one time or another, may note at least a slight external discharge. Such a discharge does not mean always that a pathologic lesion is present, for the endocervical glands, as well as the other glands concerned with the genital secretions, may have a stepped-up secretory activity under the stimulus of pregnancy and may produce an excess of otherwise normal secretions. Also, in certain emotional states the genital secretory glands may become hyperactive in a manner similar to the hyperactivity of the sweat glands under similar conditions. This excessive secretion, however, is not, strictly speaking, a leukorrhea as it is merely an increased amount of normal genital secretions.

The normal secretion in the vagina is distinctly acid with a pH ranging from 3.8 to 5. Any shift out of this normal range tends to set the stage for in-

bacteria may increase it to the neutral point of 7. The normal acidity of the secretions in the vagina is maintained by the large, gram-positive, Doderlein bacilli which produce lactic acid by their metabolic action on the glycogen normally present in the vaginal epithelial cells. Any condition which interferes with the growth of the Doderlein bacilli or with the deposition of glycogen in the vaginal epithelial cells will increase the pH with an accompanying detrimental effect on the normal vaginal flora and will enhance the growth of pathogenic invaders.

The normal vaginal debris contains numerous, desquamated, large, epithelial cells and many leukocytes in addition to the Doderlein bacilli. During pregnancy the desquamation of the vaginal cells is intensified, and a milky, curdy discharge is complained of by many women during gestation. Prior to puberty and after the menopause with estrogen levels absent or at a low titer, the squamous epithelial lining of the vagina is thin, consisting of only a few cell layers in contrast to the thick, multilayered epithelium of the woman during the childbearing years. There is little or no glycogen in the prepuberal or postmenopausal vaginal cells, and the Doderlein bacilli are rare because of insufficient nourishment. Susceptibility to infection is definitely greater in these periods because of the lack of lactic acid production. The same fact holds true during and immediately following menstruation when the alkaline menstrual flow partially neutralizes the lactic acid in the vaginal secretions.

Vulva

Although the vulva is an external structure, vulvar secretions may contribute to or be solely responsible for the discharge complained of by the patient. The most important glands of the vulva from the standpoint of producing secretions are the mucus-producing Bartholin's glands and the Skene's or paraurethral glands, which function to lubricate the introitus and the vulvar structures. Infections of either the Bartholin's glands or Skene's glands may lead to a purulent discharge from the ducts or from ruptured abscesses and may be interpreted by the patient as being of a vaginal, leukorrheal nature. The diagnosis of these infections is usually simple and can be made by gentle stripping of pus from the ducts of the involved glands. Chronic purulent discharge from the Skene's and Bartholin's ducts is an indication for excision of the glands provided relief is not obtained with antibiotic therapy. Chronic infections of these glands are often due to the gonococcus, but may be caused by other organisms.

Vulvitis due to the *Trichomonas vaginalis*, to a

Read before the Atlanta Clinical Society, September, 1952, Atlanta.

fungus infection, or to a nonspecific bacterial infection may cause or contribute to an increased discharge. Infections of this nature are usually associated with and secondary to vaginal infections. Their diagnosis and treatment will be considered under that heading.

Allergies involving the vulvar tissues and various types of eczemas may, at times, be responsible for the symptoms. Consultation with a dermatologist may be needed for the proper diagnosis and treatment in cases of this type.

Vagina

Infection Due to *Trichomonas Vaginalis*.—Vaginitis is one of the most common causes of leukorrhea. The most frequent etiologic agent is the flagellate protozoan, *T. vaginalis*. The organisms are actively motile, are slightly larger than a white blood cell, and are easily identified in a fresh saline preparation from the vagina. They are difficult to differentiate from white blood cells unless they are in motion, and it is important in making the diagnosis easy to keep the saline as near body temperature as possible while one is making the microscopic examination. The patient with this infection usually complains of leukorrhea associated with pruritus along with burning and soreness of the vulva. The discharge is often accompanied by an unpleasant odor and is of a yellowish, frothy appearance. The infection shows little tendency to involve the urethra or vulvovaginal glands as does that caused by the gonococcus, though such infection may occur. The mucous membrane of the vagina usually has a rather characteristic appearance, being inflamed and reddened with a strawberry appearance which is almost pathognomonic. This strawberry appearance is usually typical of long-standing infections. The cervix sometimes presents small erosions.

There is still uncertainty as to the source of the vaginal infection. Some have thought that the organisms have their origin in the rectum, but recent work by Allen and Butler¹ has not supported this view. Transmission of the infection by contaminated instruments, towels, and bath water must be considered, but this is rarely possible to demonstrate in any given case. It now seems clear, however, that the disease can be transmitted by coitus. Reports of chronic urethritis and prostatitis in the male due to this organism are appearing in the literature. Cases of recurrent infections in the female can occasionally be traced to a chronic infection in the male partner.

In addition to vaginal involvement, the bladder is occasionally involved with the production of an acute or chronic cystitis. The vesical and urethral infections nearly always clear up spontaneously after the vaginal infection is brought under control. Infections of the urinary tract rarely occur without an accompanying vaginal infection. Recently, however, I saw a patient with a chronic cystitis due to the trichomonas without any evidence of vaginal involvement. I would suspect that a vaginal infection had preceded the infection of the bladder.

The treatments for *T. vaginalis* vaginitis are protean. Many different drugs and varying schemes of treatment are evidence enough that in many instances this infection is difficult to eradicate. Recurrences

are common. In the light of what is now known, however, some of these may have been reinfections from the male partner rather than a true recurrence.

Some of the drugs which have been used in treating this condition are: (1) 1 per cent silver picrate (a trichomonacidal drug); (2) beta lactose designed to promote the growth of the Doderlein bacillus, thereby increasing the lactic acid production, which in turn lowers the pH to a normal range where the trichomonads cannot thrive; (3) diodoquin,[®] a trichomonacidal drug which in combination with lactose and dextrose is marketed as floraquin;[®] (4) lactobacillus therapy using vaginal tablets containing the *Lactobacillus bulgaricus*; (5) aureomycin and terramycin; (6) phenylmercuric acetate and nitrate; and (7) the pentavalent arsenical preparations phenarsone sulfoxylate (aldarsone[®]), carbarsone (cinquarsen[®]) and acetarsone (devegan[®]).

In my hands the pentavalent arsenicals are the most effective drugs in combating *Trichomonas* infection. These drugs are more rapidly trichomonacidal than the other agents mentioned, therefore give the patient more rapid relief, and in my opinion reduce the recurrence rate. With the exception of devegan,[®] they are not combined with carbohydrates. This fact does not diminish their effectiveness since once the trichomonads are destroyed in great numbers the normal vaginal flora rapidly returns, reverting the pH of the vagina to a normal range spontaneously. As for toxic reactions to the arsenic, in several hundred cases treated with these drugs during the last six years I have observed no untoward reaction.

In my experience the treatment of choice is as follows: After the diagnosis is confirmed by examination of a fresh saline preparation, the vagina is thoroughly dried with cotton balls and then insufflated with a powdered form of one of the arsenical drugs mentioned. At the present time aldarsone[®] is being used. The patient is instructed to have no sex relations and to take no douches during the course of insufflation therapy. This procedure is repeated on alternate days, for three treatments. Home therapy is begun two days after the last insufflation and consists of having the patient take an acid douche, using either vinegar, or acid powder which adjusts the pH of the solution to 3.5, each night at bedtime, followed by the insertion of a vaginal tablet or suppository (aldarsone[®]) of the arsenical drug being used. This therapy is continued for one month. If a menstrual period intervenes, the treatment is varied slightly in that an arsenically medicated tampon (Allen's Tampons[®]—acetarsone) is employed instead of the vaginal tablets or suppositories. The regular treatment is resumed after the period. Continued therapy during the menstrual period is extremely important in preventing recurrences as the alkalinity produced by the menstrual blood in the vagina increases the pH and enhances the growth of the trichomonads still viable. After the completion of the month's course of vaginal tablets or suppositories subsequent treatment consists of using the medicated tampons for the next two periods. If the fresh saline preparation then is negative for trichomonads, the patient is considered to be cured.

During pregnancy, *T. vaginalis* vaginitis is exceedingly difficult to cure not only because of the technical difficulty of administering the therapy, but also because the accompanying hyperactivity of the endocervical glands encountered during pregnancy increases the quantity of the relatively alkaline cervical mucus, thereby enhancing the growth of the offending organisms. No attempt therefore is made to effect a cure during pregnancy, but an effort is made to control the infection with its accompanying disagreeable symptoms. Control is accomplished with occasional vaginal insufflations of aldarson[®] powder when the symptoms are present. One must exercise great care when insufflating the vagina during pregnancy because of the danger of air embolism. With care, insufflation can be carried out without danger provided air pressure within the vagina is kept at a minimum. Following the pregnancy, if the vaginitis has not cleared up, the patient is given the full course of the therapy described.

The only disadvantage to the arsenical drugs, in my experience, is that they are about twice as expensive as the other agents used in treating this infection. I believe, however, that the superior results justify the increased cost.

Mycotic Vaginitis.—Second only to *T. vaginalis* as a cause of vaginitis is *Monilia albicans*, also called *Candida albicans*. In addition to leukorrhea the infection produced by this species of yeastlike fungi causes intense pruritus and vulvar irritation. The pruritus is more severe than that associated with a *Trichomonas* infection. Secondary bacterial infections of the vulva due to scratching may occur in severe cases. The vaginal discharge is characteristic in most cases, being of a white caseous type often associated with plaques on the mucous membrane. There is usually a pronounced reddening of the entire vaginal mucous membrane and also of the vulvar tissues. The diagnosis, as a rule made clinically, can easily be confirmed by microscopic demonstration of the fungi either with a gram-stained vaginal smear or, simpler still, in a fresh saline preparation such as is used to demonstrate trichomonads. In doubtful cases it has been my practice to use Sabouraud's medium, which on incubation will show fungus growth within 24 hours if these organisms are present. On the smears and in the saline preparations when fungi are present one sees the long, threadlike fibers or mycelia to which are attached the tiny buds or conidia. As with the *Trichomonas* infection, the mode of contamination with the fungi is not certain, but it seems that dissemination of the infection is by means of the hands, towels, coitus, clothing, bath water and instruments. Individual susceptibility may also, and probably does, play a part.

This infection, as with *Trichomonas* vaginitis, occurs rather commonly in pregnant patients, apparently because of the more favorable pH for fungus growth which the secretions of the vagina during pregnancy present. It is also frequently met with in diabetic patients in the form of diabetic vulvovaginitis. These patients, as a rule, show great improvement as the diabetes is brought under control, but

specific treatment for the vulvovaginitis may be required.

As is the case with *Trichomonas* vaginitis, numerous preparations have been advocated for monilial vulvovaginitis. The old stand-by for years has been 1 or 2 per cent gentian violet or bismuth violet solution. Other methods, helpful in some cases, include the use of a number of preparations in which sodium propionate, employed for a long while by bakers to inhibit fungus growth in bread, and calcium propionate have been incorporated, propion gel[®] for one. This preparation can be used at home by the patient. It is introduced into the vagina by a special vaginal applicator. Floraquin[®] containing diiodoquin, a fungicidal as well as a trichomonadical drug, has been used to combat fungus infections with some success. The preparations containing phenylmercuric acetate or nitrate and marketed as nylmerate jelly[®] and merpectogel[®] have been advocated for fungus as well as for *Trichomonas* infections. Usually, however, a preparation specifically designed for a particular infection is superior to a cure-all "shot-gun" remedy.

The specific preparation I use for fungus infections is a powder consisting chiefly of thymol, a powerful fungicidal drug, sodium perborate, another fungicide, sodium lauryl sulfate added to lower the surface tension of the preparation and several aromatics. This powder is similar in composition to the proprietary product Trichotine[®] but is much more effective because of a more potent concentration of the thymol. In 1942, Minnich³ improved the Trichotine[®] formula by increasing the concentration of thymol. The next year, Rogers⁴ reported good results with the use of this powder. The formula is: thymol, 0.2 per cent; menthol, 0.1 per cent; sodium lauryl sulfate, 3.0 per cent; oil of wintergreen, 0.1 per cent; eucalyptol, 0.1 per cent; and sodium perborate, q. s.

Once the diagnosis of a fungus infection is made, the vagina is thoroughly swabbed out with an aqueous suspension of this powder. The patient usually receives great relief from a single treatment, but to insure a cure she is advised to douche with an aqueous solution of the powder (2 teaspoonsful per quart of warm water) twice daily for two weeks and then once daily for another two week period. More than one office treatment is rarely needed. To aid in preventing recurrences, care should be exercised to insure the proper application of this suspension in the region of the clitoris as fungi are often harbored beneath the prepuce. Results with this type of therapy have been excellent.

Secondary monilial vaginitis is being reported in cases in which aureomycin and terramycin therapy is administered for various disorders. These potent antibiotic agents destroy the normal vaginal flora, thereby making possible luxuriant fungus growth. For this reason I have thought it inadvisable to employ aureomycin or terramycin therapy locally in combating *Trichomonas* vaginitis. Also, every female patient who is receiving aureomycin or terramycin therapy systemically should be watched for possible development of a fungus vaginitis. The manufac-

turers of these antibiotics are now combining two fungicidal drugs, methylparaben® and propylparaben,® with each capsule of these drugs, a prophylactic measure designed to decrease the incidence of these undesirable secondary fungus infections.

Senile Vaginitis.—The term senile vaginitis should probably be replaced by either postmenopausal vaginitis or atrophic vaginitis. This condition occurs in women during and after the menopause. Atrophy and thinning of the squamous epithelial lining of the vagina render it prone to infection. Because of estrogen deficiency, the vaginal mucosa resembles that of childhood. Frequently tiny areas of excoriation and ulceration occur which may lead to vaginal bleeding. The most common symptoms, however, are leukorrhea, pruritus, and burning and soreness in the vaginal area. Dyspareunia, due to contraction of the vaginal lumen, is another not infrequent symptom. The discharge is usually rather thin and at times may be bloodstained.

The cardinal principle of therapy involves the conversion of the thin, atrophic, vaginal mucous membrane into the thick healthy type of mucosa observed in women of the menstruating years. This is accomplished with small doses of estrogen over a short period of time. Doses which are too large or which are administered over long periods of time may reactivate the endometrium and produce bleeding of uterine origin. This effect is to be avoided because of the anxiety as well as the uncertainty of etiology which it produces. Several plans of therapy have been advanced, any of which will usually give a good result. Stilbestrol in doses of 0.5 mg. daily for two weeks will bring about great improvement. Some prefer intramuscular injections of 5,000 to 10,000 I. U. of one of the parenteral estrogen preparations once or twice a week for a month.

Personally, I prefer to use local rather than systemic estrogen therapy since just as good a result can be obtained with much less danger of endometrial stimulation. Premarin vaginal cream® containing 0.625 mg. of natural conjugated estrogens per gram is one of several good estrogenic preparations for vaginal use. It is marketed with a vaginal applicator which is graduated in grams so that the desired dose can be given with accuracy. The usual dose is 1 Gm. of the cream placed in the vagina at bedtime each night for three weeks. There is usually great improvement after this single course of therapy, but if a second course should be necessary, an interval of a week should intervene.

The vaginal mucosa of the woman in the postmenopausal period is not responsive to estrogen to the same degree as the mucosa of a child. Nevertheless, a satisfactory result can usually be obtained although the therapy may have to be repeated from time to time.

Gonorrheal Vaginitis in Children.—The thin epithelial lining of the vagina of the child is not as resistant to the gonococcus as is the adult vagina with its many layers of squamous epithelium and absence of glands. Gonococcal infection of the vagina in children usually also involves the vulva, producing a vulvovaginitis. The infection is spread through

contact between the child and an infected adult or child, but, more commonly, by an indirect route from contaminated fingers, toilet seats, towels and bathtubs. It is occasionally transmitted by rape incited by the old superstition that coitus with a child will cure gonorrhea. In children's institutions the number of cases at times may reach epidemic proportions. This infection, as in the adult population, is much more frequently observed in the clinic class of patient than in the private patient. The chief and usually the only symptom is a persistent vaginal discharge sometimes slight in amount, sometimes profuse. There is often considerable irritation about the vulva. The discharge is usually of a yellowish white color. If untreated, the disease runs an extremely chronic course, but with the onset of puberty with the accompanying estrogenic action on the vaginal mucosa it usually disappears. In children the infection rarely ever ascends into the tubes.

The diagnosis of gonococcal vulvovaginitis can be made with certainty only by microscopic demonstration of the gonococcus in the vaginal smear, and this is not always easy. The finding of the typical intracellular diplococcus is essential for diagnosis. Cultures may be needed. Some other causes of leukorrhea in children to be considered in the differential diagnosis are pin worms, foreign bodies, and infections due to the colon bacillus, streptococcus, and *Micrococcus catarrhalis*.

The examination of a child's vagina is best made through a nasal speculum. Often when examination is not possible, smears taken from the region of the introitus may demonstrate the causative organism.

Until recent years the treatment of gonococcal vulvovaginitis in children was grossly unsatisfactory. Prolonged therapy with the various silver preparations such as silver nitrate and argyrol® and with mercurochrome® was used with poor results. In 1933 Lewis² advanced the use of estrogens in treating this disease in children. TeLinde and Brawner⁵ subsequently used vaginal suppositories containing 1,000 I. U. of estrogen, one nightly for a period of three weeks, and reported almost 100 per cent cures. The principle involved, of course, was to produce an adult type of vaginal mucosa which would be resistant to the infection. This change can be accomplished with stilbestrol, 0.1 mg. daily for two or three weeks. The hormonal method of treatment is effective, but has one disadvantage in that some children will experience undesirable systemic effects of the estrogen in the form of vaginal bleeding and breast enlargement. With the advent of the sulfonamides and, particularly, penicillin the hormonal method has been largely abandoned; however, these two methods might at times be advantageously combined. The recommended treatment at present would be to use penicillin in doses of 300,000 units intramuscularly daily for a period of four or five days. Follow-up smears, of course, would be indicated. Parents of the children as well as the children themselves should be impressed with the extreme contagiousness of the disease and should be instructed about proper precautions to prevent dissemination of the infection.

Vaginitis of Mixed Origin.—The organisms singly, or more commonly in combination, which usually cause vaginitis of mixed origin are the colon bacillus, various strains of streptococci and staphylococci, and the *Micrococcus catarrhalis*. These organisms rarely cause inflammation of the vagina unless a foothold is provided for them by chemical trauma in the form of irritating douche solutions, by mechanical trauma from instrumentation or foreign bodies in the vagina with necrosis of the vaginal epithelium, or by trauma during intercourse. The chief symptom is leukorrhea. The treatment of choice is the use of vaginal suppositories of furacin,[®] a potent bactericidal drug, or of one of the sulfonamide vaginal creams. Results are usually uniformly good.

Cervix

Since the mucus glands of the cervix produce the predominant component of the secretions normally present in the vagina, it is not surprising that they are the major source of leukorrheal discharge. The secretion from the cervical glands is normally a clear, viscid, alkaline mucus. The viscosity as well as the pH varies at different phases of the menstrual cycle, both factors being most favorable for spermatozoon permeability at the time of ovulation. Secretion from the cervix may be increased by hyperactivity of the glands due to hyperemic or endocrine factors. Chronic passive congestion of the pelvic organs due to generalized pelvic relaxation may be a factor in some cases. In these situations the character of the secretion is not altered, but the amount is increased. This increase occurs most frequently during pregnancy, but may also occur in certain disturbed hormonal and emotional states.

The histologic structure of the cervix with its many gland invaginations makes it subject to acute and chronic infections characterized by abnormal secretions. The most common type of leukorrhea from this source is yellowish white in color and of a mucopurulent nature. The infection may be due to the gonococcus, streptococcus, or other types of organisms. In addition to acute and chronic cervicitis, ulcerations of the cervix due to carcinoma may produce leukorrhea. The discharge associated with carcinoma may be thin and watery at first, but in later stages becomes profuse, has an offensive odor, and usually contains blood.

In acute and chronic cervicitis, speculum examination may disclose an inflamed portio vaginalis, or a normal portio vaginalis with a purulent discharge from the cervical canal, as commonly occurs in chronic endocervicitis. Before therapy is instituted, any suspicious cervix should be subjected to biopsy to rule out carcinoma. Cervical smears should be made to detect the gonococcus, a rare etiologic agent in the private patient but one rather commonly observed on the clinic services. Usually, however, cervicitis is secondary to childbirth trauma to the cervix either from deliveries or abortions.

Acute cervicitis, particularly if of gonococcal origin, should be treated with an adequate course of penicillin therapy. Under no circumstances should the acutely inflamed cervix be cauterized as a generalized pelvic cellulitis may result.

Electrocauterization with the small nasal type cautery is the method of choice in treating chronic cervicitis, the cervix being visualized through a bivalve speculum. No anesthesia is required for the procedure as the cervix is relatively insensitive to heat. Strokes with the cautery are usually made in a radial fashion extending outward from the external os. The depth of the cauterizing strokes as well as their extent will depend, of course, on the degree of cervical involvement. When the external os is small, the cauterization should not be carried into the cervical canal, but if it is wide and patulous, cautious superficial strokes may be made into the infected mucosa of the canal. Great care must be exercised as a cervical stricture may result. Whenever the cervical canal is entered with the cautery, proper follow-up treatment should include periodic dilatation of the cervix.

Healing with re-epithelization of the portio vaginalis of the cervix following cauterization is usually satisfactory. It is often remarkable to observe how an hypertrophied, eroded and boggy cervix is transformed by cauterization into a small cervix hardly distinguishable from a nulliparous one. Leukorrhea, the presenting symptom in most cases, usually rapidly clears up as healing occurs. The only after-care consists of daily douches of either vinegar or one of the pH-adjusted acid douche powders. Complete healing ordinarily takes place in about six weeks. Occasionally it is necessary to recauterize, but ultimately healing will occur. When there is extensive cauterization, healing may be speeded up by the use of either vaginal suppositories of furacin[®] or one of the sulfonamide vaginal creams such as Ortho triple sulfa cream.[®]

In some cases of chronic endocervicitis the portio vaginalis is of normal appearance, but issuing from the external os is a chronic mucopurulent discharge. In my experience the best therapeutic result in these cases is obtained by gentle dilatation of the cervical canal at weekly intervals combined with penicillin therapy. These dilatations can be carried out in the office with a minimum of discomfort to the patient. The improved drainage from the infected glands as a result of the dilatations along with the antibiotic action of the penicillin often clears up the leukorrhea in a short time.

For those cervixes too severely lacerated and diseased for cure by the methods mentioned there remains cervical amputation or, on occasion, total hysterectomy if a more extensive procedure is indicated. Occasionally, conization or trachelorrhaphy may be the procedure of choice, but these procedures are not as widely used as they once were.

Uterus

In past years the uterus was thought to be the source of many chronic discharges originating from a chronic endometritis. Now it is known that leukorrhea rarely has its origin above the level of the internal cervical os and that chronic endometritis seldom exists as a clinical entity.

Tubes and Ovaries

Infections of the tubes and ovaries do not in themselves cause leukorrhea except perhaps second-

darily through the pelvic hyperemia which they produce. The abnormal discharges often associated with these infections have their origin lower down in the genital tract.

Conclusion

In conclusion, it can be said with certainty that the final answer to the problem of chronic leukorrhea has not been written. In most cases, gynecologists can diagnose, treat and cure the conditions responsible for this disorder, but there remain a few cases of obscure etiology which may baffle even the most experienced gynecologist.

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The Incidence of

RETROLENTAL FIBROPLASIA

In Premature Infants

Despite the many reports in the current ophthalmic literature regarding the incidence of retrolental fibroplasia in premature infants, to our knowledge none have been published as the result of a systematic study of the eyegrounds of premature infants born in the southern section of the United States. Lack of such a report has led to the widespread belief that perhaps retrolental fibroplasia is a rare or at least a very uncommon disease in this part of the country. That this assumption is incorrect has been shown in the results of several different studies conducted in the Atlanta area. This report gives in detail some of the findings of one of these studies, a survey of all surviving premature babies at Grady Memorial Hospital from November 1, 1951 to November 1, 1952.

The patients, all of whom were admitted to the Grady Memorial Hospital premature nurseries at, or shortly after, birth, were first examined by an

ophthalmologist at the age of two or three weeks, depending on the size and physical condition of the infant. Thereafter, the eyegrounds were examined every two weeks. Once the disease was diagnosed, the eyegrounds were examined every week.

The diagnosis of retrolental fibroplasia was made on the presence of any of the signs of the disease,^{1 2} such as dilated and tortuous retinal vessels, neovascularization in the periphery of the retina, new vessels in the vitreous, membrane formation, retinal detachment, and the presence of retinal hemorrhages, when accompanied by one or more of the other findings. The diagnosis was made usually in the earliest stages of the disease. Complete regression of the condition was a common occurrence. The fact that in most of the infants showing evidence of retrolental fibroplasia the disease regressed spontaneously leaving very little, and at times no evidence of a past disturbance, would seem to make worthless a survey of prematurely born infants at any age beyond that of two or three months. A survey made at a later age would reveal only those eyes with severe permanent damage, namely those with a vitreous membrane or a partial or a complete retinal detachment.

The following tables give the essential findings of the twelve month survey.

*From the Department of Ophthalmology, Emory University School of Medicine, and Grady Clay Memorial Eye Clinic, Grady Memorial Hospital, Atlanta, Georgia.

TABLE I

Grouping of Premature Infants According to Race, Sex
and Birthweight
(Examined between Nov. 1, 1951 and Nov. 1, 1952)

	Admissions	Number Examined*	Over 1500 Gm.	Under 1500 Gm.
White Males	50	35	31	4
White Females	32	21	17	4
Colored Males	142	98	79	19
Colored Females	132	100	79	21
Totals	356	254	206	48

*102 infants admitted during the period of study died before a fundus examination was made.

TABLE II

Total number of premature infants showing evidence of
retrolental fibroplasia during twelve month period (Between
November 1, 1951 and November 1, 1952)

	Birthweight over 1500 Gm.	Under 1500 Gm.
White Males	5	4
White Females	1	2
Colored Males	7	9
Colored Females	7	14

Total number of Prema- tures showing some evi- dence of retrolental fibroplasia	20	29
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TABLE III

Visual result in infants with a severe form of the disease

Name	Color	Sex	Birthweight	Visual Result
W	W	F	1485 gm.	Partially blind, both eyes
C	C	M	1395 gm.	Partially blind, right eye Blind, left eye
D	C	M	1245 gm.	Blind, both eyes
D	C	F	1500 gm.	Blind, both eyes
S	W	M	1815 gm.	Blind, both eyes
T	W	M	1175 gm.	Blind, both eyes
H	W	M	1075 gm.	Blind, both eyes

Summary

Only four infants showing evidence of retrolental fibroplasia had birthweights of over 2,000 gm. No baby with a birthweight of over 2175 gm. was affected. Analysis of tables I and II shows* that, in this series, 19.3 per cent of premature infants surviving and examined showed some evidence of retrolental fibroplasia, that 60.4 per cent of premature infants with a birthweight of less than 1500 gm. showed evidence of the disease and that 9.7 per cent of premature infants with a birthweight of more than 1500 gm. showed evidence of the disease. Table III indicates that five cases, or 17.2 per cent of affected infants of birthweight less than 1500 gm., were blind or nearly so. Two cases or 10 per cent of the affected infants with a birthweight of 1500 gm. or over, developed blindness.

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Van Meter Award

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Boston, Massachusetts, April 29, 30 and May 1, 1954, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English, and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1954. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

Radiological Research Grants

Applications for grants from the James Picker Foundation for Radiological Research, headed by Mutual Security Director Harold E. Stassen, may now be submitted for next year. In the past three years, funds totalling \$80,000 have been made available to mature investigators to further broaden the uses of radiology for the good of mankind.

Awards of grants, fellowships, and scholarships are given in support of a specific research program under the direction of a responsible investigator. Any project offering promise of improvement or development in radiological methods of diagnoses or treatment of disease is eligible for assistance from the Picker Foundation.

Applications for grants-in-aid and fellowships should be directed to: James Picker Foundation, Inc., Hanover Bank Trustee, 70 Broadway, New York 4, N. Y., or Secretary, Division of Medical Science, National Research Council, 2101 Constitution Avenue, N. W., Washington 25, D. C.

Final applications should be submitted no later than November 30, 1953.

SYMPATHECTOMY *for*

PERIPHERAL VASCULAR *Disease*

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The present study was undertaken as an evaluation of the clinical results obtained in 104 patients who have undergone sympathectomy of one or more of their extremities for peripheral vascular disease during the period between October 1946 and March 1952. Because this operation is being carried out with increasing frequency and enthusiasm it was felt that an evaluation should be made.

Mahorner's² excellent classification of peripheral vascular disease is presented (Chart I). This review of cases does not include the entire gamut of this classification. Particularly is it deficient in instances of Raynaud's disease, as 99 per cent of the patients seen at the Lawson V.A. Hospital are males. No comment will be made regarding the efficacy of sympathectomy on those disease entities not treated in this clinic. Chart II gives a summation of the use of sympathectomy at the Lawson V.A. Hospital.

CHART I

- Mahorner's Classification of Peripheral Ischemia
- I. Arteriosclerosis (A) Senile (B) Diabetic
 - II. Thromboangiitis obliterans
 - III. Embolus and thrombosis
 - IV. Injury (A) Contusion of artery
(B) Laceration or severance of artery
 - V. Aneurysm
 - VI. Post-traumatic vasospasm (Sudeck's atrophy; causalgia; pneumatic hammer disease)
 - VII. Raynaud's disease
 - VIII. Frostbite
 - IX. External pressure (Baker's cyst; cervical rib)
 - X. Chemicals and drugs (lead and irradiation)
 - XI. Intravascular clotting (leukemia; polycythemia)
 - XII. Blood volume flow disturbances (anemia, shock)

CHART II

	Number of Cases	Immediate Results			Late Results			
		Good	Satis.	Poor	Good	Satis.	Poor	Unknown
Arteriosclerosis obliterans.....	35	22	8	8	17	10	5	6
Thrombosis of aorta.....	3							
Thromboangiitis obliterans.....	18	9	8	1	6	5	3	4
Post-thrombophlebitic state.....	11	6	2	3	1	2	7	1
Frostbite.....	8	8	0	0	6	2	0	0
Causalgia.....	14	14	0	0	5	0	6	3
Trauma acute.....	4	1	0	3	1	0	0	3
old.....	9	9	0	0	9	0	0	0
Epidermophytosis with hyperhydrosis.....	2	0	0	2	0	0	2	0

*Surgical Resident Lawson V.A. Hospital, Chamblee, Georgia. July 1948-June 1952. Now Associate Surgeon, Lexington Clinic, 190 North Upper Street, Lexington, Kentucky.

From: Surgical Service, Lawson V.A. Hospital, Chamblee, Georgia and Emory University School of Medicine, Emory University School of Medicine, Emory University, Georgia.

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This paper was awarded first prize in the 1952 annual contest sponsored by The Georgia Chapter, American College of Surgeons.

Technique

Lumbar sympathectomy: The patient is placed in the supine position with a sand-bag under the hip of the side to be operated upon. In this manner the lumbar gutter may be readily exposed. A transverse incision, approximately 10 cm. in length, is made at the level of L-3 beginning at the lateral border of the rectus muscle and extending laterally. This is carried down through the external oblique muscle. The internal oblique and transversalis muscles are split in the direction of their fibers revealing

the peritoneum which is rolled medially exposing the lumbar gutter. The sympathetic chain is found under the lateral border of the vena cava on the right, or aorta on the left. It is dissected free from the diaphragmatic crus to the pelvic brim and removed, the rami being clipped with silver clips. This removes the ganglia of L-2, L-3 and occasionally L-4. The wound is then closed without drainage in layers with fine silk. The results should be evident immediately as evidenced by a warm, dry foot.

When bilateral sympathectomy is indicated the procedures have been done at intervals of 10 days. It is felt that the two-stage method reduces post-operative ileus and other complications.

Dorsal sympathectomy: The sympathetic chain innervating the upper extremity is most easily reached by a transpleural approach. The patient is placed in the lateral position with the axilla exposed. Under positive pressure endotracheal anesthesia a portion of the third rib in the axilla is removed, the pleural cavity opened, and one can then easily dissect free the sympathetic chain from the stellate ganglion through C-5. The removal of the lower half of the stellate ganglion through at least the 4th thoracic sympathetic ganglion is necessary to insure complete sympathetic denervation of the upper extremity. The wound is closed in layers with fine silk. The chest is drained for 24 to 48 hours by means of a water-seal catheter drainage system.

Material and Results

Arteriosclerosis and Thrombosis of the Aorta: Thirty-eight patients were sympathectomized because of this disease—three with thrombosis of the aorta and 35 with arteriosclerosis obliterans. Aortic thrombosis was treated with bilateral lumbar sympathectomy in each instance. Nineteen patients underwent the bilateral procedure for arteriosclerosis and 19 had only a unilateral sympathectomy. At the present time the feeling at this clinic is that a bilateral procedure should always be done for peripheral ischemia due to arteriosclerosis as the best results are obtained early in the disease and the clinically uninvolved extremity will receive excellent prophylactic treatment. Frequently the patient will state that much improvement has occurred "in my good leg."

The mechanism of sympathectomy should be understood in this group before evaluating the results. The resection of the sympathetic nerves does not in any way change the process already present in the vessels, nor does it change the progressive course of the disease. Spasm or the natural tension in the arterioles is released allowing a greater volume of blood per unit of time to reach the extremity. In case of thrombosis of the aorta and iliac vessels no effect is noted on these major trunks, rather one notes an increase in the volume carried by the collateral circulation. Thus we see that with the progressive disease untouched one can only hope for temporary relief—but this temporary relief may last for a period of years. Again one must stress that if the procedure is done early, before the vessels are ravaged, that the result will be more striking and the

number of good results increased. One may not expect the dramatic results that one obtains from closure of a perforated ulcer or removal of an acute appendix. The surgeon and the patient must be satisfied with a return, if only partial, of function to a useless painful leg.

The three thrombosed aorta cases have all received fair improvement. The immediate results in the remaining 35 were good in 22, satisfactory in eight and poor in eight. The late results were good in 17, satisfactory in 10, poor in five and unknown in six instances. A good result is defined as one in which the patient notes marked subjective improvement as regards pain, in addition he is able to get about increasing his activities. The foot and leg are warm and dry. A satisfactory result is one in which the patient may not feel much relief, but the foot is warmer, incipient gangrene has not occurred, and the surgeon may judge that he has saved a leg. A poor result is one which receives no relief from pain, nor does he have an increased exercise tolerance or may require an amputation within six months of the sympathectomy.

Sympathectomy for severe cases of arteriosclerosis has been incriminated as the agent causing immediate gangrene of the extremity, the theory being that the arterioles are opened shunting the limited amount of blood available into these vessels and starving the capillaries. A number of such cases have been studied in detail³ and present opinion seems to indicate that the loss of the extremity in each case has been due to a small embolus or thrombus coincidental in its formation to the sympathectomy.

Thromboangiitis Obliterans: Eighteen patients with thromboangiitis obliterans or Buerger's disease have been seen. Ten have had bilateral lumbar sympathectomy, eight have had a unilateral lumbar sympathectomy and five of these 18 patients have had a dorsal sympathectomy. The immediate results have been good in nine, satisfactory in eight and poor in one instance. The late results are unknown in four and must be assumed to be poor, three have had unsatisfactory late results, five satisfactory, and six excellent. The six excellent results are not due to the sympathectomy, but are due to the understanding of the patient that complete abstinence from tobacco is the vital factor in the proper and effective treatment of this disease. Only six individuals in this group have completely abstained and they are the six excellent results. Two patients who have continued to smoke have died of mesenteric thrombosis due to thromboangiitis obliterans.

The amount of tobacco is not paramount for apparently the individual has an idiosyncrasy to tobacco which is responsible for the reaction in the vessel walls. One professional musician, after a remission of two years, went to work in a smoky cabaret and after two weeks he was again suffering from the disease despite the fact that he was not actually smoking. Upon leaving his job his symptoms again subsided. Another patient, a traveling salesman, gained relief only after he stopped lighting

cigarettes for his wife while she drove him about the country.

The feeling of this clinic is that sympathectomy serves to tide the patient over a crisis in the course of the disease, and that in such a case it may well save an extremity. It is an aid to the healing of ulcers on the hands or toes, or in the good wound healing obtained upon amputating a finger or toe. As in arteriosclerosis it has no direct effect upon the systemic disease. Other valuable adjuncts which have been used in co-operation with sympathectomy have been the oscillating bed, intra-arterial priscoline and histamine, typhoid fever therapy, anti-coagulants, alcohol by mouth, antibiotics, and, where necessary, amputation. In our experience systemic priscoline has not proved effective.

Frostbite: Eight patients have been treated for frostbite with impressive immediate results. The late results have been good in five and satisfactory in three. It is apparent that the earlier the sympathectomy is done following the occurrence of the injury, the better the results will be.⁴ The full extent of the injury may not be evident early in the patient's course, and in these cases early sympathectomy will undoubtedly conserve tissue. Several of these cases of frostbite were so severe and were seen so late in the disease that amputation of toes or part of the heel was necessary as a primary procedure. However, the results following sympathectomy were spectacular in that the granulation tissue rapidly formed and was firm and healthy. These patients appeared to be ready for plastic repair much more quickly than past experience without sympathectomy indicated. There was a reduction of pain and they demonstrated a greater exercise tolerance.

Causalgia: Causalgia of an extremity due to old war wounds brought 14 patients to lumbar sympathectomy. All 14 patients had immediate relief of pain and the results were considered excellent. Six patients, however, have complained of a return of their pain, in some instances it has been of less severity. In one or two instances the desire for increased compensation may have been a factor. Five have remained well and three have not been followed (A good sign in this disease, since it was service induced). The results in this entity justify the continuation of the procedure for causalgia.

Post-Traumatic Sequelae: Nine patients have undergone sympathectomy because of the sequelae of old trauma which could not be classified as causalgia. Several of these have been below knee amputations with a cold, blue, sweaty stump which is easily damaged by and would not tolerate the prosthesis. Others have had localized areas of pain but have not been classified as causalgia or Sudeck's atrophy. Each of these nine patients has gotten an excellent result.

Acute Trauma: Four patients have undergone emergency sympathectomy in conjunction with the debridement and repair of acute wounds to the extremity where the major arterial trunk was impaired or destroyed. In only one instance was the extremity saved. This poor result does not mean that one should hesitate to employ this operation as an aid to a severely damaged extremity. It may well mean

a longer, more normal stump if it does not mean that the limb is completely saved.

Hyperhydrosis: Lumbar sympathectomy for epidermophytosis and hyperhydrosis has yielded disappointing results in each of two cases tried.

Post-Thrombophlebitic Syndrome: Eleven patients have had lumbar sympathectomy because of this syndrome—four bilateral and seven unilateral procedures. The results have been poor in 10 and satisfactory in only one. In addition these patients have been treated with rest, elastic bandages and vein ligations. Sympathectomy does not seem effective for this syndrome, except in occasional well selected cases.

The 137 operations have been complicated by two deaths (pulmonary embolus and coronary occlusion), two severe wound infections, two instances of atelectasis, one non-fatal pulmonary embolus, one instance of cystitis, and postoperative pain in both thighs in one patient.

Summary

Sympathectomy has been evaluated as a treatment for several types of peripheral vascular disease. The results of 148 sympathectomies in 104 patients have been outlined, and the merit of the procedure for each disease entity indicated.

Conclusions

1. Sympathectomy is of value in arteriosclerosis obliterans, especially in its earlier stages.
2. It is a valuable tool in the treatment of acute Buerger's disease. Total abstinence from tobacco gives the patient the best long term result.
3. It is of value in causalgia, old and acute trauma, and frostbite.
4. It is of doubtful value in the treatment of the post-thrombophlebitic state and of hyperhydrosis with epidermophytosis.

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Eye Bank Donations

The Ponce de Leon Infirmary, Atlanta, is affiliated with the national Eye Bank in New York—The Eye Bank for Sight Restoration, Inc.—and is offering their service for those who wish to donate their eyes to the Eye-Bank at time of death. Any physician who has patients who desire to do so may secure all forms necessary for this service. The staff of the Ponce de Leon Infirmary is available at any hour to obtain eyes of a donor. Eyes must be removed under sterile conditions and within two hours after death. They must be transplanted within 72 hours. The family physician can notify the Infirmary and all arrangements will be made.

From time to time the *Journal* will publish articles of pertinent economic interest to the physician. The first of this series, "Can You Retire, Doctor?", by Dr. Robert Scharf, Georgia Institute of Technology and published in the March *Journal*, excited much interest and has been widely reprinted. Your comments are invited.

Investing in STOCKS and BONDS

JACK F. GLENN, Atlanta

Some physicians are seasoned investors and thoroughly familiar with the accepted principals of investing in stocks and bonds. Others may be like the one who said he had always thought "stocks" were horses and cows, and "bonds" were where they were kept. The majority of physicians will have a knowledge of the subject which falls in a category somewhere between these two extremes. Now because professional men make up a group whose knowledge of investing in stocks and bonds varies greatly, this discussion and the terminology employed must of necessity be very general in nature.

Investing is not an exact science; therefore, there is no "magic formula" for successful and satisfactory investing. It is impossible to tell a group exactly *what* stocks or bonds should be bought or *when*. It is even impossible to say whether everyone in a particular group should ever buy stocks and bonds. It is hoped that this will not be a disappointment to you.

In this discussion one should consider only the basic concepts of investing and the correct mental approach to the subject of investing in stocks and bonds. One should not follow the usual procedure of discussing how to read a balance sheet or how to read an income statement. Likewise one should not discuss economics, taxes, and the effect of war on the various stocks and bonds. Instead, an attempt should be made to strip the veils and clouds of mystery and misunderstanding from this business of investing in stocks and bonds and show that with the correct basic concept; the right mental approach, investing can be as simple as adding two and two and getting four. If we succeed in this attempt, it should be helpful to the seasoned investor as well as to the novice. Let's then get on with our "unveiling," and start the "dance of the Seven Veils."

How shall we start? Well, we're talking about money, so a good place to start is with the dollar. There's an old saying that "there's nothing funny about money" and this is certainly true. There is nothing funny about anything for which we work so hard and yet which slides through our fingers so easily. It becomes thought provoking when we con-

sider that some people work eight hours, 10 hours, or 15 hours a day, six or even seven days a week in an attempt to *make* more dollars, and yet I dare say, not one doctor in a hundred will spend a few minutes a week, or even a month, in *planning* how he will make those dollars for which he works, *work* for him.

But when he has earned a dollar, just what can he do with it? First, he can "save" it. He can put his dollars in a hole in the ground, between the mattress covers, or in a bank. If he puts these dollars in a safe place, then he can come back a day later, a month later, or several years later and find the same number of dollars. True, the dollar may have appreciated in value or depreciated in value, in accordance with what it can buy, but he will have the same number of dollars. That is "saving." Second, he can "buy" things with his dollars. He takes his dollars and exchanges them for something else which may quickly depreciate in value. He buys food, but when the food is gone it cannot be turned back into dollars. He can buy a railroad ticket and take a trip, but when the trip is completed he can't exchange his railroad ticket for dollars. He can buy an automobile, or clothes, but after they have been used they cannot be exchanged for the same number of dollars they cost. Thus, when we "buy" things we exchange our dollars for tangibles or intangibles which quickly depreciate in terms of those dollars for which they were exchanged. Third, he can "invest" those dollars. When we invest we simply take our dollars and exchange them for something tangible or intangible, but with the belief that at some later date we can exchange that tangible or intangible something back into an equal amount of or more dollars than we started with; in the meantime, those dollars will work for us by providing dividends on common stocks, interest on bonds, rent from real estate, or maybe just pleasure and enjoyment, such as we obtain from the ownership of our home.

Let's explore further the meaning of "investing" and prove to ourselves that when we "invest" our dollars we do not "buy" stocks and bonds but merely make an "exchange." The government slogan "Buy

Assistant President, Citizens and Southern Bank, Atlanta.

War Bonds" has always seemed poorly phrased because a person "invests" in war bonds and does not "buy" them. For example, place a \$100 bill in one hand and a \$100 government bond in the other; look at them, they are both pieces of paper. On both there is printing in black and green ink; both say \$100; both say United States of America. You can take the piece of paper we call a hundred dollar bill and exchange it for the piece of paper we call a government bond and by the same token you can take the piece of paper we call the government bond and exchange it for the piece of paper we call a hundred dollar bill. There is really no difference between the two in value. The only real difference, and we will discuss this later, is how these two pieces of paper can be used. Pursuing this example one step further, one can see that when you "buy" General Motors stock you merely exchange that type of paper we call dollars for that type of paper we call a stock certificate. There is no certainty that you can exchange the stock certificate for the same number of dollars or more dollars than you started with, but at the time you acquire the General Motors stock you expect to be able to do so.

Going further into the definition of investing, it is generally accepted that investing encompasses a five point program and to explain these five points, one may use as an example, the young doctor starting out in practice. The *first* thing he should do is to acquire a nest egg of cash, or government bonds which can readily be converted into cash. This asset will always take care of the unexpected emergency. Then he should make provision for those dependents he now has, or may have in the future. Therefore point number *two* is the embarking upon a well-planned life insurance program. Also everyone should have a home of his own. Point number *three* is the planning and making provisions for the acquisition of a home. Point number *four* is not always looked upon as a factor in an investment program but it is just as important as any of the others. There are the old sayings that are as true as they are trite, "they don't put pockets in shrouds" or "you can't take it with you." Isn't it ridiculous for a man and his wife to work hard all of their lives, to skimp and save for the future and then die and have the entire estate completely dissipated or go to those persons in whom they have no interest? Therefore, point number *four*, and an important point, is the making of a will. Then and only then, do we get to point number *five*, which is investing in stocks and bonds.

Let us dispense then with discussing the term "investing" by remembering two very important facts. *One*, when we invest in stocks and bonds we do not "buy" in the ordinary sense of the word. We merely exchange our dollars for another piece of paper which we believe will better satisfy our needs and, *two*, the investment program is a five point program and we should not think of buying stocks and bonds until we have a nest egg, an insurance program well on the road, provisions made for the purchase of a home, and a will.

To continue the discussion of investing in stocks and bonds we must know what stocks and bonds are, and, even more important, we must know the *characteristics* of common stocks, preferred stocks and bonds.

Common stocks, of course, represent ordinary ownership of a business. The price of the common stock is governed by many factors. Primary among these factors is the amount of money the company earns per share of common stock and the amount of this money the company pays out in the form of dividends. The larger the earnings and the larger the dividends, then the higher will be the price of the stock. Now should these earnings decline and the dividends become in jeopardy, then the price of the stock may be expected to decline. In those companies where the earnings and dividends are relatively stable over a period of years, we may expect the price of the stock to remain relatively constant, but in those companies which in one year earn good money and then go through a period of poor earnings, followed by a year or more of good earnings, and back again to poor earnings, we may expect the price of the stock to fluctuate quite violently. What, then, are the characteristics of common stock. They represent ordinary ownership. There is no limit to how high the price of the stock may go and zero is the only limit to which the price of the stock may fall. Stocks with a steady earnings record will remain fairly steady in prices; those whose earnings fluctuate violently may be expected to fluctuate likewise in cost price.

The preferred stock also represents ownership, but ownership with certain privileges. Generally speaking, preferred stock will pay a set amount per share in dividends regardless of how much the company earns except, of course, if earnings are not enough to pay dividends, in which case the amount of dividend may be reduced or eliminated entirely. In most cases the preferred stock can be redeemed at five to 10 per cent above the price at which it is originally sold. So long as earnings are adequate to assure the payment of the fixed dividend, then the price of the preferred stock will remain fairly constant. If, on the other hand, the earnings drop off to a point where the preferred stock dividend is in jeopardy, or to the extent where the dividend must be eliminated, then one can expect the price of the preferred stock to decline. Preferred stock will not go much above its issue price, for obviously no one would pay 20, 50, or a 100 per cent above the issue price with the knowledge that the preferred stock can be redeemed or bought in at any time at only five or 10 per cent above the issue price. As in the case of the common stock, if earnings continue at a rather constant rate the price of the preferred stock will remain rather constant. If, on the other hand, the earnings of the company fluctuate violently, the price of the preferred stock can be expected to fluctuate in the same manner. What, then, are the characteristics of the preferred stock. It represents ownership but with special privileges—if earnings remain adequate, the price of the preferred stock will

remain at or close to the price at which it was originally offered to the public; if earnings decline, the price of the preferred stock could decline to zero. Also, as in the case of the common stock, if earnings remain constant, the price will remain constant; if earnings fluctuate violently, the price of the preferred stock will do the same.

Bonds do not represent ownership, they represent the debt of a corporation. Bonds do not pay dividends, they pay interest. Bonds are always issued with the provision that they will be redeemed or paid at a certain date, just as the usual bank loan matures on a certain date. The rate of interest on bonds is usually constant for the life of the bond just as interest on a bank loan is constant during the terms of that particular loan. Bonds are usually quoted in terms of what must be paid for \$100 principal amount. If the earnings of a corporation are adequate to insure the payment of the interest on the bonds, one can expect the bonds to sell at or close to 100. Regardless of how good conditions may be within the company, the bonds will never sell greatly above \$100, for obviously no one will pay a \$150 or \$200 per \$100 principal amount of the bonds knowing that in a specified and relatively few years the bonds will be paid off at \$100 per bond. If on the other hand, earnings decline to the point that the payment of interest is questionable, the bonds may decline to a very low value. As in the case of common stocks and preferred stocks if earnings remain fairly constant, the price of the bonds remains fairly constant; if, on the other hand, earnings fluctuate violently the price of the bonds can be expected to fluctuate violently.

In case the company liquidates or dissolves itself, either voluntarily or involuntarily, then after the creditors are paid the bond holders are paid first, then the preferred stockholders and, if anything is left, it goes to the common stockholders.

From this discussion of stocks and bonds one notes that *in any one company* the bonds are the strongest investment, followed by the preferred stock, and lastly the common stock. It should be repeated that this is *in any one company*. It does not take much imagination to see that the common stock of an old well-established company with constant earnings and steady dividends payments can be much safer and much stronger and have less fluctuations in price than even the bonds of a new "fly-by-night" corporation.

There are two things known about stocks and bonds: one is that the prices of stocks and bonds will always fluctuate, and two, is that the yield (the dollar return in the form of interest or dividend per dollar invested) will also fluctuate. Now it so happens that stocks and bonds which have a long record of steady earnings will fluctuate very little in price and the history of such stocks and bonds which have little price fluctuation is that the yield is relatively low. For emphasis, let it be said again that small price fluctuation usually means a small yield, but the converse is not necessarily so, for some securities with a small yield may fluctuate in price quite violently. By the same token, securi-

ties with a high yield, that is a large dollar return in the form of interest or dividends per dollar invested, will fluctuate quite a bit price-wise. Again one should remember that while high yield usually means large price fluctuation, the converse is not true, because a stock which fluctuates widely does not mean it will afford a high yield.

We see then that stocks, both preferred and common, and bonds have two characteristics: (1) the price movement, and (2) the yield (dollar return per dollar of investment.) Stocks and bond can then be classed according to these two characteristics of price and yield. They can be put into separate and distinct categories. How many categories, one might ask. That is like asking how many colors are there in the rainbow. It is generally stated that there are seven colors in the rainbow, yet one might go to a store and find dresses in more than a dozen different shades of red alone. For this discussion it can be stated that there are three categories into which we can group bonds and stocks, but here, too, each category could be subdivided.

Category one includes those stocks and bonds which have relatively small price fluctuations and afford a relatively small yield. It includes companies whose earnings have, through the years, remained relatively constant and whose dividends have been adequately provided. The interest or dividend yield rate will, therefore, be relatively low. Stocks and bonds in this category are government bonds, municipal bonds, the highest grade bonds of corporations, and the highest grade preferred stocks of certain companies.

Category two includes stocks and bonds whose prices do fluctuate and whose yield is a little larger than that of those securities in Category one. This group encompasses good, but not the best bonds of corporations, good, but not the best stocks of corporations, and can include the very best common stocks of old, long-established companies.

Category three may include bonds, preferred stocks, and common stocks. In this group one finds stocks and bonds whose prices do fluctuate quite violently and whose return in the form of dividend or interest per dollar invested also fluctuates to a large degree.

One might say, "What must I know in order to place the various stocks and bonds in their proper grouping or category?" It is necessary to be well versed in the reading and understanding of income statements, and balance sheets. One must know quite a bit about economics, world events, the effect of taxes and war on the operations of the various industries and companies within the industries. One must know something of management, and follow developments from day to day.

"Oh," the physician says, "I thought we were going to have a simple discussion. I am busy with my practice all day long, and it is impossible for me to keep up with all those things just mentioned." This information can be obtained in the same manner your wife obtains a new dress. If through the years she has been taught to sew, how to cut a pattern, has ability with the needle and has some imagination, she can make for herself a finer dress than can be

bought from an expert dressmaker. If, on the other hand, she has not been taught these things and does not have the time to make a dress, she goes down to the local dressmaker or to the fashionable store in the community and buys the dress. The price of the dress, of course, includes not only the material but the ability and know-how of the person who made it. By the same token, you can buy this information from a stock and bond broker, an investment counsel firm (if there is one conveniently located) or you can obtain this information from the trust and investment department of a bank. It is no more difficult for you to obtain this information than it is for your wife to obtain a dress which she does not make herself.

It has been said that many men who are supposed to be well-educated, intelligent, and informed, state that common stocks, preferred stocks, and even bonds should never be purchased. "They are too dangerous." This is certainly untrue. A razor blade is one of the most dangerous things that can be placed in the hands of a child or in the hands of someone who doesn't know how to use it, but when put in a safety holder and put in the hands of a man, it is never considered dangerous and has certainly added a great deal to our way of living. By the same token an automobile is probably the most dangerous machine man ever invented when placed in the hands of an inexperienced driver. And yet, when placed in the hands of a person who really knows how to drive and drive safely, the automobile is as harmless as a kitten and if we did not have the automobile, it is needless to say just how far removed from our present day civilization our world would be. Stocks and bonds are dangerous in the hands of persons who do not know how to use them, but when employed by you either directly or through your broker, investment counselor, or banker, they, too, are as safe as a kitten and can add a great deal to your way of living in added income both now and in later years.

Now we have discussed the term "investing"; we have discussed what stocks are, what bonds are, and have seen their characteristics. It has been shown that stocks and bonds can be grouped according to their time proven characteristics of price movement and yield. How shall we proceed? It was not so long ago that investment houses proceeded to solve the problem of investing in this manner. "Here," they say, "are three lists of stocks and bonds. List No. 1 is for the man or woman who wishes to invest \$25,000. List No. 2 is for the person who wishes to invest \$10,000. List No. 3 is for the person who wishes to invest \$5,000. The Research Department has been working on them for months. We don't believe anyone could criticize them."

So, Dr. "Jones" looks at List No. 1 since he has \$25,000 to invest. "Well," he says, "I know a little something about stocks and bonds and this does appear to be a good list, but it doesn't exactly suit me. I have saved quite a good deal of money and there are too many stocks and bonds in this list which are in that class you described as remaining relatively constant in price. I can afford to 'speculate' a

little bit more. Can't you get me up another list with securities that go up and down and thus afford the opportunity of buying low and selling high?" That surprises us somewhat, for we thought we had the perfect list, but Dr. "Jones" is certainly correct. Let's then show the same list to Dr. "Smith." He has exactly the opposite reaction to this list. He wants stocks and bonds which remain relatively constant in price and he observes that there are a few stocks in the list whose prices do fluctuate. He requests us to rearrange the stocks and bonds so that practically all of them are in that category which remain practically constant in price. Here, then, we have a fine list that we have shown to two people and it suits neither one of them and for exactly the opposite reason.

Why is this? It is because each one of us has an *investment objective*. We live in different economic strata and there is no one list of securities which fits all people. For example, suppose we had tailored a suit of double-breasted clothes made of the finest possible blue material and had it on display at the next medical meeting. We explain that this very suit can be obtained at one-fourth of its cost and asked Dr. "Brown" if he would like to have it. Dr. "Brown" admits that it is a fine suit but he is a little on the fat and short side and the suit is made to fit a man of average height and build; therefore, he can't use it. Suppose we ask Dr. "Green" if he would like the suit. He is of average height and build. Dr. "Green" says the suit is a beautiful suit, but it just so happens he can't wear blue. Dr. "Black" is a man of average height and build and always wears blue but he can't use the suit either, because he just can't wear a double-breasted suit. Thus, we have a fine suit of clothes which everyone agrees is a thing of beauty and yet the first three doctors to whom the suit is offered cannot use it and all for a different reason.

For a suit to be attractive to each of these doctors, it must be tailored to their needs and, by the same token, the list of stocks and bonds which is attractive to each individual must be tailored to his need. Too many times we have heard the individual say, "I think I will buy some of "XYZ Corporation" common stock, for I heard the president of our cotton mill say he was going to buy some." This has caused more headaches than aspirin can cure. It is just as ridiculous as a person without an automobile saying, "I think I'll buy "XYZ" automobile *insurance* because the president of our cotton mill said he bought some and that it was extremely cheap."

It is necessary to further examine this question of your investment objective and how it applies to securities. Here is a \$50 bill. Here is a \$50 Series E Government Bond and here is a \$50 Series F Government Bond. All are paper; all have green and black printing on them; all say United States of America; and all are worth \$50 today. Today, each of these three pieces of paper can be exchanged one for the other, but they have different characteristics. The \$50 bill does not grow through the years, it does not pay interest, but it can be spent for goods and services. The Series E Bond cannot be spent and it does not pay interest each year but through the

years it does grow in value. The Series G Bond cannot be spent today, it does not grow in value but each year until maturity it pays 2½ per cent.

We can ask Doctor No. 1 which of these pieces of paper he would prefer. He wants the \$50 bill because it can be spent immediately and he has gotten a little bit behind with his groceryman and his butcher. Doctor No. 2 takes the Series E Bond. He does not owe his butcher or his groceryman; he does not need additional income right now. He knows that by buying the \$50 Series E Government Bond and holding it for a few years, it will grow to be worth \$62.50. Doctor No. 3 chooses the Series G Bond which pays him 2½ per cent interest each year. He does not need money to pay his current bills to the butcher, baker, and the candlestick maker; he is not particularly interested in long term appreciation, but he is interested in obtaining more income right now. Thus, we see there are three pieces of paper, each of equal value, each can be exchanged for the other and yet when we offer them to three different doctors, each doctor chose a different piece of paper. Why? Simply because each doctor had a different *investment objective*.

Thus, we have seen that stocks and bonds have various characteristics of price movement and of income and that these stocks and bonds can be grouped into various categories, depending on these characteristics. We have also seen that we, as individuals, have certain characteristics or *investment objectives*. This, then, brings us to the \$64 question. If you have spare dollars, does any group of stocks and bonds have characteristics which appeal to you more than do the dollars? Are your *investment objectives* such that the characteristics of a certain group of stocks and bonds of more value to you than are the characteristics of the dollar? If so, the investment problem is easy. You merely exchange your dollars for stocks and bonds in that category which better fulfill your investment objectives than do the dollars. Don't worry about which individual stock or individual bond you buy. If they are in the category that fits your objectives, don't become grey-headed trying to pick that one which will out-perform all others. Who can say whether General Motors will out-perform Chrysler over the next 10 year period of time. Who can say whether U. S. Steel will out-perform Republic Steel over the next 10 years or who can say whether Reynolds Tobacco

will out-perform Liggett-Meyers over the next 10 years. No one can, or if they do try, it is nothing in the world but a guess.

Now in getting someone to help you group the various stocks and bonds into their proper category and then fitting this category to your *investment objective*, don't rely on a friend or a successful businessman or a successful doctor or a relative simply because he is successful. If he is successful the chances are he is just as busy in his work-a-day world as you are in your profession and has no more time to study those factors necessary to make successful investments than you do. There is the case of a lady whose husband died and left her extremely wealthy. Her income exceeded her expenses and she had the problem of investing this surplus. She went to see her lawyer, her brother-in-law, her banker, and her stock and bond man. Each one suggested a different security. Needless to say, she was completely confused. Now why did all of these intelligent men suggest a different security. Either because they were thinking in terms of their own *investment objective*, or more probably because each one recognized her *investment objective* and merely suggested a different stock in the proper category. It should be added that the poor lady finally selected one person whose business it was to advise in investments and she is now perfectly happy with her investment program.

It has been said that there is no magic formula to investing. But remember these important factors: *One*, you don't buy stocks and bonds in the ordinary sense of the word "buy," you merely swap your dollars for another type piece of paper; *Two*, there are five steps in the investment program and you are not ready to invest in stocks and bonds until you have your nest egg, your insurance program, provisions for your home, and your will prepared; *Three*, stocks and bonds have definite characteristics as to price movement and yield and can be grouped in accordance with these characteristics; *Four*, you have a definite *investment objective* of your own; *Five*, your investment problem can be solved by matching the desired characteristics obtainable from certain stocks and bonds to your own investment objective; *Six*, remember to get competent help with your investment program. While there is no magic formula to investing, an understanding of these six basic concepts will take one a long way down the road to successful investing in stocks and bonds.

Medical Technology Courses

Oglethorpe University, Atlanta, recently announced the initiation of a new program in science for men and women leading to a career in medical technology. The first session will begin September, 1953. The program embraces three academic years of work on the Oglethorpe campus in the premedical curriculum followed by a full 12 months period of

intensive instruction and practice in one of the laboratories of a cooperating Atlanta hospital. Hospitals cooperating with this program are Crawford W. Long Memorial Hospital, Piedmont Hospital, St. Joseph's Infirmary and Atlanta Veterans Administration Hospital.

MAG

PUBLIC RELATIONS *Committee Meeting,*

Macon, July 12, 1953

Members present at a meeting of the public relations committee July 12 at the Dempsey Hotel, Macon, were as follows: Chris J. McLoughlin, Chairman, Atlanta; Peter L. Scardino, Savannah; Thomas L. Ross, Jr., Macon; J. Lamont Henry, Atlanta; J. L. Chandler, Jr., Augusta; and George R. Dillinger, Thomasville.

Also in attendance were: Peter B. Wright, Augusta; David Henry Poer, Atlanta; Mark S. Dougherty, Atlanta; William R. Golsan, Macon, Henry Tift, Macon; Milford B. Hatcher, Macon; and Messrs. Sid Wrightsman, Jr. and Milton D. Krueger, both of Atlanta.

Chairman McLoughlin called the meeting to order at 11 a. m. and presented as suggestions to the committee a number of objectives for committee action for the ensuing year. It was made clear that the projects outlined by McLoughlin were open to discussion and that the group should consider these suggestions in that light.

Projects outlined for committee discussion by the chairman were as follows:

(1) A method of solicitation of funds from the profession in Georgia for the specific use of the committee to enable the committee to carry on its projects.

(2) A drive to increase MAG membership.

(3) A plan for effecting better cooperation among the members of MAG in relationships between themselves.

(4) Small press conferences to be held on the local level from time to time to improve relations between the press and the profession.

(5) A representative from the profession in each local county to be a press representative for the profession.

(6) Supply each newspaper in the state with a list of these physicians (see No. 5) who will speak for the profession and handle queries from the press.

(7) Local county society promotion, origination and support of any radio and TV facilities made available to the profession in their areas.

(8) MAG sponsored exhibit and First Aid station at the Southeastern Fair Exhibit to be held in Atlanta.

(9) Publicity program to inform the public of medical service available to *all* patients.

(10) Establishment of Mediation Committees in

all local societies and publicity for public as to their function.

(11) Establishment of emergency-call system in all counties and towns or cities with phone book listing.

(12) Promotion of a public forum (based on Fulton County format) on a state-wide basis in at least 10 cities at the same time to begin in the fall of this year.

(13) Industrial relations program.

(14) Office public relations, ie: training receptionist, etc.

(15) MAG Medical Economic Bureau to investigate ability of patients to pay, bill collecting, etc.

(16) Placement Service by MAG, especially for physicians returning from service with armed forces.

(17) Medical Speakers Bureau on a state-wide basis for lay groups to call on, etc.

Each of these projects were discussed and considered and it was the opinion of the committee that the whole program was excellent and feasible. The committee further felt that initially a few specific projects could be effected and the whole program put into action at later dates.

The following motion was made by Thomas L. Ross, Jr., and seconded by Peter L. Scardino:

That the committee approve (1) the direct solicitations of funds to support further committee work; (2) the instituting of county society mediation committees and emergency-call systems; (3) the medical forums be instituted on a state-wide basis.

This motion was passed by the committee.

Mark S. Daugherty made the motion that the *Journal of The Medical Association of Georgia* carry an editorial and a solicitation clip-coupon to aid in the committee fund raising project. The motion was passed by the committee.

Mark S. Daugherty was named committee treasurer and checks for committee funds shall be made out to him.

A motion was made to adjourn the meeting at 2 p. m.

ANNOUNCEMENTS

AUGUST 18: Spalding County Medical Society will meet at 6:45 p.m. in the Griffin-Spalding County Hospital, Griffin.

AUGUST 20: Habersham County Medical Society will meet at 7:30 p. m. at the Commercial Hotel, Cornelia.

AUGUST 20: Tenth District Medical Society is scheduled to meet in Thompson.

AUGUST 31: Polk County Medical Society will meet at the Wayside Inn, Cedartown at 7:30 p. m.

SEPTEMBER 1: Upson County Medical Society will hold a 7:30 p. m. meeting at the Upson County Hospital, Thomaston.

SEPTEMBER 1: Tift County Medical Society will meet at 7:30 p. m. at the Tift County Hospital, Tifton.

SEPTEMBER 2 and 3: The 1953 Medical Public Relations Institute sponsored by the AMA will be held at the Drake Hotel, Chicago. Representatives from state and county medical societies are invited to participate in the program. For additional information write: Public Relations Department, American Medical Association, 535 N. Dearborn, Chicago, Illinois.

SEPTEMBER 3: Coffee County Medical Society will meet at 1:00 p. m. at the Douglas Hospital, Douglas.

SEPTEMBER 3: Fulton County Medical Society will meet at 7:30 p. m. at the Academy of Medicine, Atlanta.

SEPTEMBER 3: Ware County Medical Society will hold their meeting at the Ware Hotel in Waycross at 7:30 p. m.

SEPTEMBER 4 and 5: The Fifth Annual Meeting of the Georgia Heart Association will be held at the DeSoto Hotel, Savannah. There is no registration fee and all physicians are invited. Hotel reservations should be made direct to the DeSoto Hotel, Savannah. Scientific sessions will maintain the high standards of past years.

SEPTEMBER 4: Jenkins County Medical Society will meet at the Screven County Hospital, Sylvania, at 7:30 p. m.

SEPTEMBER 4: Chattooga County Medical Society will meet at 7:30 p. m. at the Chattooga County Hospital, Summerville.

SEPTEMBER 7: Cobb County Medical Society will meet at the Kennestone Hospital, Marietta, at 7:00 p. m.

SEPTEMBER 7: Telfair County Medical Society will meet at 8:00 p. m. at the Telfair County Hospital, McRae.

SEPTEMBER 8: Altamaha Medical Society will meet at the Appling General Hospital in Baxley at 8:00 p. m.

SEPTEMBER 8: South Georgia Medical Society will meet at 7:30 p. m. at the Country Club, Valdosta.

SEPTEMBER 8: Decatur-Seminole Medical Society will meet either in Bainbridge or Donalson.

SEPTEMBER 9: Ninth District Medical Society will meet at 3:00 p. m. at the Hall County General Hospital, Gainesville.

SEPTEMBER 9: Tattnall County Medical Society will meet at 1:00 p. m. at the County Courthouse, Reidsville.

SEPTEMBER 10: Jefferson County Medical Society will meet at 8:00 p. m. at the Jefferson Hotel in Louisville.

SEPTEMBER 11: Randolph-Terrell Medical Society will meet at the Patterson Hospital, Cuthbert, at 8:00 p. m.

SEPTEMBER 14, 15 and 16: The Tri-State Postgraduate Obstetrical Seminar will convene for a three day meeting of Georgia, South Carolina and Florida physicians. The Headquarters hotel is the Sheraton-Plaza Hotel at Daytona Beach, Florida.

SEPTEMBER 14: Walton County Medical Society will meet at 7:30 p. m. at the VFW Home, Monroe.

SEPTEMBER 14: DeKalb County Medical Society will meet in the DeKalb County Health Building, Decatur, at 7:30 p. m.

SEPTEMBER 15: Spalding County Medical Society will at 6:45 p. m. at the Griffin-Spalding County Hospital, Griffin.

SEPTEMBER 16: Whitfield County Medical Society will meet at 7:30 p. m. in the Hamilton Memorial Hospital, Dalton.

SEPTEMBER 16: Thomas County Medical Society will meet at 6:00 p. m. in the Archbold Memorial Hospital, Thomasville.

SEPTEMBER 16: Tri-County (Calhoun-Early-Miller) Medical Society will meet in Blakely at 8:00 p. m.

SEPTEMBER 17: Habersham County Medical Society will meet in the Commercial Hotel, Cornelia, at 7:30 p. m.

SEPTEMBER 17: Richmond County Medical Society will meet at 7:00 p. m. in the Old Medical College, Augusta.

PERSONALS

Leslie C. Buchanan announces the opening of his office at 215 Church Street, Decatur, with a practice limited to general surgery.

Lt. Willard P. Carson, formerly of Chatsworth, has returned from a two year tour of duty in Korea and Japan where he served as a member of the surgical staff of the 171st. Evacuation Hospital, Tague, Korea and also as a member of the surgical staff at the Tokyo General Hospital, Japan.

John L. Chandler, Jr., of Augusta, was one of 34 specialists from the United States, Canada and Sweden, who recently completed a two week course in cerebral palsy at the Cook County Graduate School of Medicine, Chicago.

Harry L. Cheves, Jr., whose graduation from the Medical College of Georgia in June marks the third generation of physicians in the Cheves family, will begin a two year internship at the University Hospital, Augusta. Twenty-nine years ago, his father, *Harry L. Cheves, Sr.*, of Union Point, graduated from the same institution and 44 years ago his maternal grandfather received his medical degree from this same school.

Jesse C. Dover and Mrs. Dover, of Clayton, recently celebrated their golden wedding anniversary. Their immediate family and their many friends joined them in celebrating this occasion.

F. Kathryn Edwards and Mary E. Walker announce the opening of offices at 112 North McDonough Street, Decatur, with a practice limited to pediatrics.

Robert G. Ellison, Department of Thoracic Surgery, University Hospital, Augusta, will limit his consulting practice to cardiovascular surgery, in view of the expanding program in both clinical and investigative aspects of cardiovascular disease now underway.

C. M. Henry, of Clarkesville, has been appointed medical examiner under the provisions of the new Post Mortem Examination Act which went into effect on May 10. He will serve four counties: Habersham, White, Banks and Rabun.

Ivey Jacobs, formerly of Columbus, has opened offices in Waycross for the practice of general medicine. He has purchased the office building formerly occupied by *Brasswell E. Collins* at 701 Elizabeth Street.

Roosevelt Peter Jackson, announces the opening of his office for the practice of medicine and surgery at 1772 Mozley Drive, S. W., Atlanta.

C. S. Jernigan, of Sparta, celebrated his eightieth

birthday recently, having completed 56 years of service to his community. The Sparta Lions Club held "a Doctor C. S. Jernigan" day in his honor.

O. F. Keen, of Macon, has been promoted to Division Surgeon of the Central of Georgia Railway Company. The appointment of *Frank Johnson*, also of Macon, as Company Physician was announced at the same time.

G. Lombard Kelly, retiring prexy of the Medical College of Georgia, was presented with a handsome leather traveling bag by *V. P. Sydenstricker* in behalf of the College faculty.

On July 1, *G. Lombard Kelly* became associated with *Robert B. Greenblatt* and *William E. Barfield* in the Department of Endocrinology, Medical College of Georgia, with a practice limited to disorders of sexual function.

Bert Malone, of Brunswick, is now radiologist at the Brunswick City Hospital and will head the X-ray Department of that institution.

J. F. O'Daniel, formerly of Macon, has opened his office in Dublin at the Thompson Building on Rowe Street and Madison Street for the practice of medicine and surgery.

David Henry Poer, of Atlanta, is the author of an article, "Primary Carcinoma of the Third Portion of the Duodenum," published in the June issue of the *Annals of Surgery*.

W. L. Pomeroy and *W. B. Bates*, of Ware County, have been appointed medical examiners.

John H. Robinson, III, of Americus, has been granted a fellowship in cancer surgery at Memorial Hospital, New York City, and assumed his duties there July 1. He will return to Americus July 1, 1954.

Harry Evan Rollings, of Savannah, addressed the medical staff of the Veterans Administration Hospital on June 24. His topic was "The Low Sodium Diet."

T. A. Sappington and *Herbert D. Tyler* have accepted appointments to serve as medical examiners in Upson County.

W. R. Schnauss, of Adel, recently addressed the Adel Lions Club on the topic of "Polio."

The Neuroclinic, of Atlanta, announces the association of *Thomas B. Summers*, in the practice of neurology.

Brooke F. Summerour, of Dalton, has obtained a residency in anaesthesiology at Baroness Erlanger Hospital, Chattanooga, Tenn. He will continue to maintain his residence in Dalton, and at present, plans to return to Dalton to practice.

J. Calvin Weaver, of Atlanta, has returned to his office after a six weeks' convalescence following an operation June 8.

DEATHS

FLEMING: *Albert Fleming*, 86, of Folkston, died at his home in Folkston July 7. A graduate of the Georgia College of Medicine and Surgery, 1894, he was a member of Ware County Medical Society.

McFARLANE: *John W. McFarlane*, 45, of Macon, died July 1 of coronary artery disease. A member of Bibb County Medical Society, he was a grad-

uate of Wayne University College of Medicine, Detroit, class of 1938.

MILES: *William Clanton Miles*, 71, of Griffin, died in Griffin on July 12. A graduate of the Atlanta College of Physicians and Surgeons, class of 1908, he was a member of Spalding County Medical Society. He was buried in Kingsport, Tennessee.

WHELAN: *Edward J. Whelan*, 53, of Savannah, died July 10. A native of Savannah, he was a graduate of Georgetown University School of Medicine, Washington, D. C., class of 1924.

Medical-Military Data

Medical Officers Recently Released from Service in Armed Forces

Dr. Frank L. Garner, 781 Wilson Rd., N. W., Atlanta, Ga.

Dr. Thomas C. Nolan, 275 Buford Place, Macon, Ga.

Dr. William F. Prior, Jr., Soperton Road, Rt. 6, Dublin, Ga.

Dr. Virgil C. Wade, 111 "D" Court, Olmstead Homes, Augusta, Ga.

Dr. James W. Pate, Route 1, Waycross, Ga.

Dr. Joseph L. Caldwell, Jr., 149 Damascus Road, Augusta, Ga.

Dr. Marvin A. Jackson, 801 East 3rd Ave., Dawson, Ga. (c)

Dr. Phil C. Astin, 13 West Chandler St., Carrollton, Ga.

Dr. Henry B. Hearn, Eatonton, Ga.

Dr. Harry E. Rollings, 120 East Gaston St., Savannah, Ga.

Dr. Thomas D. Johnson, 1554 Shoup Court, Decatur, Ga.

NATIONAL ADVISORY COMMITTEE

To The Selective Service System

INFORMATION RELEASE NO. 3

SUBJECT: RESIDENCIES

The National Advisory Committee in considering residents who are special registrants and the Health Resources Advisory Committee in considering residents who are reserve officers have adopted the following general policy. As has been customary in the past, each case must be considered separately on its merits and delays or deferments to serve as residents are based on the needs of the hospital rather than to permit an individual physician to continue or complete a training program.

Priority I and Priority II: Practically without ex-

ception these men should be considered available for service and should not be deferred to accept or to continue in residencies for this hospital year. If they desire to serve the hospital temporarily until such time as they are called, there is no objection, providing it is understood that they are not to be delayed beyond the time that they are called to service.

Priority III. (a) *Those with double liability:* Those Priority III individuals who are under 28 years of age have double jeopardy and may be called at any time as regular registrants in addition to being subject to call as special registrants. They should enter service on the completion of their internship without exception.

(b) *Those over 28 but under 31:* They are in the group that is at present furnishing the pool to supply the needs of the armed services and should enter service after their internship. If they do not do so it will be necessary for the services to issue calls for the induction of physicians who are over 30 and are engaged in the active practice of medicine. It is highly desirable that for the next 12 months calls, if at all possible, be limited to those under 30 and if deferments are not granted in this group there probably will be a sufficient number available to fill the calls for this fiscal year.

The Committee, in reaching these decisions, has not changed its position since it has repeatedly called attention to the fact that an individual's potential liability for military service should be considered in appointing residents. This applies also to the so-called pyramid system: those individuals selected for advancement to an additional year's service as they rise in the pyramid should be those who are not liable for military service. It is essential that the hospitals cooperate in this program so that the intent of Public Law 84 be carried out and that members of the professions entering the Services are from that group which should go first according to the provisions of that law. Otherwise the calls will be on an inequitable basis and will be made unequivocally from the standpoint of the professions as a whole.

JOURNAL of The Medical Association of Georgia

SEPTEMBER • 1953

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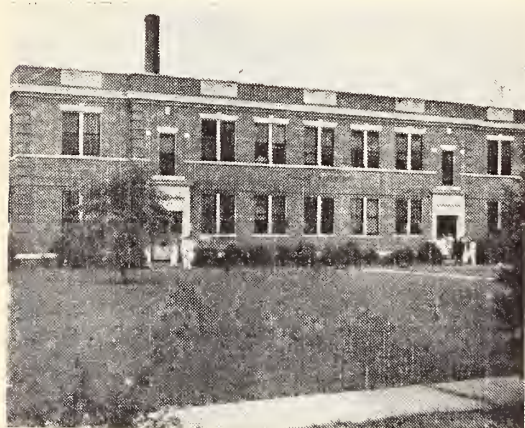


Photo by Jack Wood



Photo by Ted F. Leigh, M.D.

Fall weather and football give rise to the back to medical school theme of our cover picture. Shown above are scenes from the two medical schools in Georgia. Top picture is the Dugas building on the campus of the Medical College of Georgia and under it the cover picture which shows student activity at the Emory University School of Medicine.

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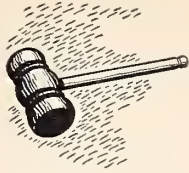
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president's page

Voluntary health insurance has played an important part in helping individuals and families to budget the major part of their medical expenses. The growth of such plans has been phenomenal, and has far surpassed the fondest hopes of those who pioneered this venture several years ago. Much of the credit for this success must be given to the cooperative efforts of the medical profession, private insurance companies, and non-profit groups.

The progress made in Georgia in the health insurance field has been well below that of many other states in our nation. These problems were discussed at an excellent insurance panel held during the Savannah meeting of the Medical Association of Georgia last May. Beginning in June, your insurance committee has been working hard to solve the problems which are known to exist. Certain changes in the Georgia Plan have been discussed, and if the objectionable features are eliminated, you will be expected to give it your whole hearted support; otherwise we will not have the success which other states have obtained. Remember that this is a vital part of our public relations program.

It has been repeatedly demonstrated that clean, honest competition between insurance companies and non-profit organizations, such as Blue Cross and Blue Shield, has been beneficial to all concerned. In other states it has been shown that if no monopoly is allowed to develop, each major insurance agency has acted as a stimulus to others, to provide more attractive plans and improve service to the public. We, who are committed to free enterprise, should use our influence to see that all voluntary health agencies are given fair and equal consideration.

It is not necessary to mention the many advantages to you as a physician of having a large percentage of our citizens covered by pre-payment plans. With your support and the leadership of our capable insurance committee, much can be accomplished.

WILLIAM HARBIN

The JOURNAL of the Medical Association of Georgia

MAKE YOUR RESERVATIONS FOR THE 1954 ANNUAL SESSION IN MACON MAY 2 - 5, 1954

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

GENERAL POLICY: The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Georgia.

MEDICAL EDITING SERVICE. If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.



physician's bookshelf

BOOKS RECEIVED

MECHANISMS OF UROLOGIC DISEASE: By David M. Davis, M.D., Professor of Urology Emeritus, Jefferson Medical College; Visiting Lecturer in Urology, Graduate School of Medicine, University of Pennsylvania. 156 pages. Philadelphia and London: W. B. Saunders Company, 1953. Price \$4.50.

PRACTICAL X-RAY TREATMENT: By Arthur W. Erskine, M.D. 4th Edition, Revised and Enlarged. 176 pages. Bruce Publishing Co., St. Paul 14, Minnesota. Price \$5.00.

NEW AND NONOFFICIAL REMEDIES 1953. Containing descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1953. Issued under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association, 1953. J. B. Lippincott Company, Philadelphia, London, Montreal. 600 pages, including Bibliography of Unaccepted Products and Index to Distributors. Price \$2.65.

PEDIATRIC CLINICS OF NORTH AMERICA—Vol. I,

Number 1A. A Symposium on POLIOMYELITIS 1953, an analysis of recent advances, and an outline of clinical management, prepared with the editorial assistance of The National Foundation for Infantile Paralysis. 60 pages. Published by W. B. Saunders Company.

PROCEEDINGS OF THE ANNUAL MEETING—COUNCIL FOR HIGH BLOOD PRESSURE RESEARCH, AMERICAN HEART ASSOCIATION—1952. Published by American Heart Association, 44 East 23rd Street, New York 10, N. Y., and printed by International Press, N. Y. Price \$1.75.

TWENTY-FIVE YEARS OF SEX RESEARCH—History of the National Research Council Committee for Research in Problems of Sex 1922-1947. By Sophie D. Aberle, Member of the National Science Board of the National Science Foundation and George W. Corner, Carnegie Institution of Washington. W. B. Saunders Company, Philadelphia — London. 238 pages.

PEDIATRICS: By L. Emmett Holt, Jr., M.D. and Rustin McIntosh, M.D. 12th Edition. 1953. 1542 pages. Appleton-Century-Crofts, Inc., N. Y. Price \$15.00.

REVIEWS

THE SURGERY OF INFANCY AND CHILDHOOD. By Robert E. Gross, M.D., D.Sc., William E. Ladd, Professor of Children's Surgery, The Harvard Medical School, Chief of Surgical Service, The Children's Hospital, Boston. Pp. 1000. Illustrations 1488. W. B. Saunders Company, Philadelphia and London, 1953.

The first edition of this superbly prepared book represents a well coordinated study of the multiple congenital, traumatic and acquired surgical problems of the neck, thorax, abdomen, rectum and urinary tract encountered in infancy and childhood.

Each region and pathological entity are dealt with in detail in a well organized and interesting style to include the embryology, etiology, clinical findings, pre and post operative therapy, operative procedure and end results.

There are separate chapters devoted to the details of pre-operative and post-operative care, anesthesia for pediatric surgery, and surgery in premature infants.

These studies are graphically illustrated by nearly 1500 diagrams, drawings, and photographs depicting the clinical findings, operative procedures, and results of the amazing volume of patients seen at the Boston Children's Hospital. The magnitude of this work is illustrated by the 211 cases of atresia and stenosis of the small and large intestines, 233 cases

of atresia of the esophagus, 156 cases of malrotation, 1787 cases of hypertrophic pyloric stenosis, 702 cases of intussusception, and 96 cases of Wilm's tumor.

This book should be available to all physicians whose responsibility includes the diagnosis and treatment of infants and children.

CALLANDER'S SURGICAL ANATOMY. By Barry J. ANSON, M.A., Ph.D. (Med. Sc.), Professor of Anatomy, Northwestern University Medical School; and Walter G. Maddock, M.S., M.D., F.A.C.S., Elcock Professor of Surgery, Northwestern University Medical School. Cloth. Pp. 1074, with 929 illustrations. W. B. Saunders Company, Philadelphia, London, 1952.

The third edition of Callander's Surgical Anatomy represents a complete revision by Drs. Anson and Maddock following the untimely death of Dr. Callander. Thus, the combined efforts of an anatomist and a surgeon, with assistance from their colleagues in the various surgical specialties, have given us this beautifully prepared and authoritative book.

There are over 900 detailed, clearly and accurately illustrated drawings, diagrams and photographs. In conjunction with the detailed anatomy and anatomical variations of each region of the body, there is a concise review of the surgical problems therein encountered. This, in many instances, includes not only the fundamental anatomical methods of surgical approach but also the embryology, pathology, anatomical physiology, indications and pitfalls of the various

surgical procedures. The anatomical illustrations of the pelvis, inguinal region, and neck are particularly outstanding.

The thoroughness and conciseness of this book are such that it can be recommended to all general practitioners, general surgeons, gynecologists, other surgical specialists and the medical student as well.

NUTRITION AND DIET IN HEALTH AND DISEASE, 6th Ed. by James S. McLester, M.D., and William J. Darby, M.D., Ph.D. 710 pages; W. B. Saunders Company, Philadelphia. 1952.

This well established and time honored textbook now in its sixth edition has a co-author, and this new life is readily evident. The book starts with a survey of the physiology of digestion and internal metabolism. It then proceeds with a scholarly presentation of the knowledge of the various foodstuffs. Diseases or groups of diseases in which dietary considerations are important are then discussed according to specific diseases and according to systems. These discussions are introduced by comments on the various basic aspects of the conditions. The dietary considerations appropriate to these conditions are then thoroughly presented both in text and in table form. The material is well up to date and is well selected and evaluated. Where controversies exist, both sides are presented.

The 84 page appendix would be valuable to any physician and especially to specialist dealing with diabetes, metabolic diseases and nutritional problems. Hospital dietitians will find the very complete tables of composition of foods useful for a reference book. The table showing sodium and potassium content of foods is especially appropriate in view of the current interest in these minerals.

The text is well documented by references to the original literature. It is well written and easily read. It will probably find its greatest usefulness as a reference book.

SURGERY OF THE PANCRÉAS: By R. B. Cuttell and Kenneth W. Warren. W. B. Saunders & Co., New York. 1953. Price \$10.00.

Any book written by recognized authorities in a special field will command serious attention and careful study by all physicians who have interest in that subject. As succinctly stated by Dr. Frank Lokey, in the Foreword, the background for the assignment of this special study for prominent members of the clinic staff is fully described along with approval of this distinguished surgeon.

The authors in this moderate sized and well styled monographs of 374 papers present subject material (based on more than 1,000 patients) in nine chapters and use 100 figures consisting of well chosen photographs, drawings, and graphs. In addition there are 41 tables summarizing the clinical information and a very complete bibliography follows each chapter.

The information contained in this book will be studied closely by surgeons and internists alike because it represents the findings in one of the largest groups of patients with pancreatic disease on that has been published. For anyone concerned with problems of treatment of diseases of the pancreas

it is highly recommended.

THE EPIDEMIOLOGY OF HEALTHS, Health Education Council, N. Y. Academy of Medicine. C. V. Mosley & Co., St. Louis, Mo. 1951. Price \$4.75

This book includes 15 papers which formed the subject matter of the Eleventh Annual Eastern States Health Education Conference. But in developing a well-rounded concept of an epidemiology of health, the contributors have gone far beyond the material presented at the conference.

For a long time, epidemiology has been associated in the minds of physicians with disease and its control, and the title, "Epidemiology of Health", may appear revolutionary to the casual reader. On reflection, however, a positive approach to the concept of health seems desirable. The scope of epidemiology is no longer confined to studies of impairment of health but is broadened to permit consideration of degrees of health.

In reviewing the growth of epidemiologic knowledge, the authors show that epidemiology is based on ecology and accordingly, it employs the data and methods of many scientific disciplines, including those of clinical medicine, bacteriology, entomology, parasitology, statistics and others. An understanding of mass disease processes may be had only through viewing at the same time and in their proper perspectives all factors concerned with disease production. This is the theory of multiple causation.

But health is not merely the absence of disease. And the epidemiology of health is more than the reciprocal of the epidemiology of disease. The mass problems of health and disease are judged to be complementary rather than reciprocal and an independent consideration of the factors which determine the two components is deemed essential.

It is pointed out that in a given population the distinction between the sick and the well is arbitrary, and the dividing line is often obscure and subject to change with improved methods of measurement. Shifts from the healthy component to the sick do not occur indiscriminately but involve those who are most susceptible. It follows therefore, that gradations of healthiness exist as well as gradations of disease, and shifts may occur within that component of the population deemed healthy as well as from the well to the sick. This marks the justification for an epidemiology of health.

Turning to the more practical aspects of the matter, current health practices in the army and in industry are reviewed. Other contributors discuss the concept of an epidemiology of health in relation to tuberculosis, mental hygiene, nutrition, geriatrics, medical practice and public health.

This is a publication of the New York Academy of Medicine. The foreword is by Howard R. Craig, M.D., director of the Academy of Medicine. Dr. Iago Goldston, member of the Academy, served as editor of the conference and wrote the initial chapter. The book is well documented. It will be of interest to all those who are concerned with the relationship of medical practice to such special fields as preventive medicine, public health, industrial medicine and others.



new drugs

Anti-inflammatory Agents

Since the discovery that cortisone would relieve the inflammation in various arthritides and dermatoses, the search for new drugs which would relieve inflammation and edema has been pushed ahead by the chemists.

Some work has been done on the hypothesis that the salicylates and other antipyretic agents had an anti-inflammatory action in arthritis because of stimulation of the anterior pituitary which in turn stimulated the adrenal cortex to produce cortisone. This hypothesis is untenable as far as rats are concerned because adrenalectomized rats become edematous following dextran, and phenergan and other agents prevent edema in these rats. Out of this work the only agent to gain fairly wide clinical trial was Phenylbutazone (Butazolidine®—Geigy). This compound is related to aminopyrine and might be expected to produce similar side effects. Unfortunately this has proved to be the case. Almost all persons treated with Phenylbutazone have responded well to the drug but a high percentage of the persons treated have some blood dyscrasia and there have been a number of cases of agranulocytosis, some ending in death. Although this agent is still considered by many as a useful drug it must be used with caution and a close observation of the white cell count must be maintained.

Various French and Swiss workers, mostly under the direction of Domengoz or Halpern, have introduced into clinical trial several phenothiazine deriva-

tives chemically related to the antihistamine Phenergan®-Wyeth.

Pharmacological evaluation of these agents has been based largely on the species-specific reaction of white rats to dextran. Dextran injected intraperitoneally into white rats produces inflammation and edema in the paws, nose and ears of rats. This reaction can be prevented by the previous injection of Phenergan or Phenindamine (Thephorin®-Hoffman-La Roche) and by a number of related agents. Although these two agents are potent antihistaminics, anti-edemic action is not necessarily involved in histamine antagonism. Most of the antihistamine drugs will not prevent edema in rats up to the fatal dose.

Domengoz has quantitated the blocking of edema and has used a variety of other agents to produce edema or inflammation. Some of the techniques have involved the injection of formaldehyde, red pepper and egg white under the skin of the paw and determining the amount of inflammation in animals treated with a test drug and those given saline.

Although most of the drugs tested so far have only half the action of Phenergan, at least one phenothiazine derivative, known as 4560 RP, is more than twice as effective as Phenergan. This compound has only slight antihistamine activity. It is hoped that an active anti-inflammatory agent can be produced which will have low toxicity and few or no side reactions.

Selective Service Information

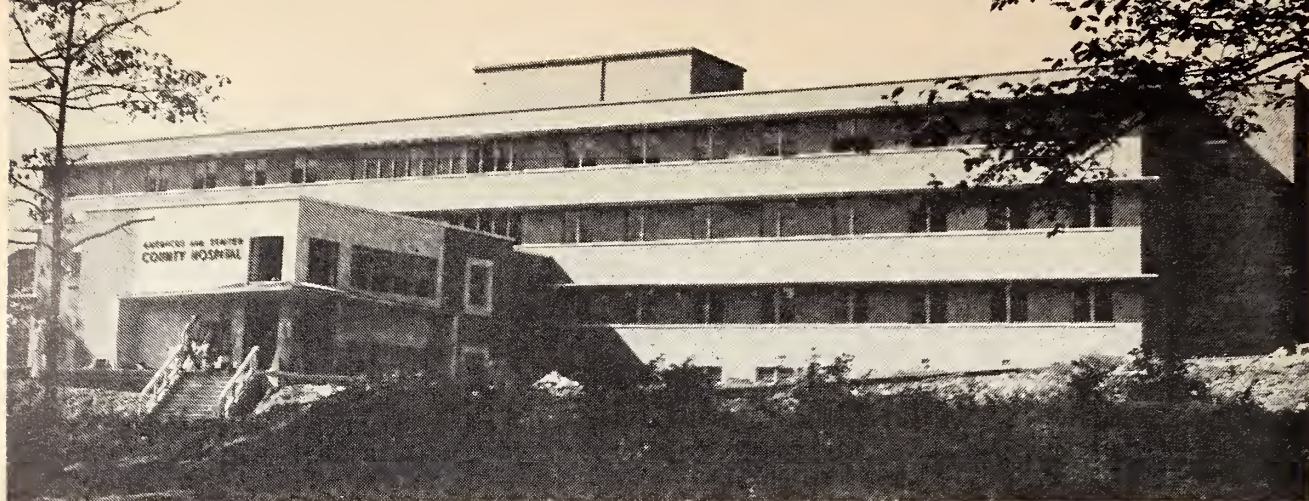
This information was released September 2 by the National Advisory Committee to the Selective Service System.

"It is not expected that there will be additional calls for physicians placed against the Selective Service System by The President for the next twelve months.

"As a result of the Selective Service Special Registrant August call and the increased number of volunteers, there have been commissioned a sufficient number of physicians to meet the needs of the armed forces for the immediate future. Those

who have been commissioned from either the voluntary list or the Selective Service Call will be brought to active duty from time to time until this reservoir is exhausted.

"Public Law 84 specifically designates that the State Medical Advisory Committee to the Selective Service System give advice in regard to residents, teachers, and research workers. As you know, this is a lull year and it will be necessary to watch situations in communities, medical schools, hospitals, etc., so that when calls are re-established we will find only, as an unusual exception, any of those who are liable, in essential positions."



Americus-Sumter County Hospital
Americus, Georgia

The Americus and Sumter County Hospital which has one hundred beds was opened for the reception of patients on January 1, 1953. There is still under construction a wing for Negro patients. This wing will provide accommodations for 30 patients. When

completed the entire hospital will have a bed capacity of 130 beds and 30 bassinets. The old Sumter County Hospital of 43 beds and Prather Clinic of 31 beds have been closed. The Americus Colored Hospital of 34 beds will be closed when the accommodations for Negro patients at the Americus and Sumter County Hospital are ready for the care of patients.

hospital page

Hospital Construction in Georgia

Most physicians in Georgia are aware of the Hospital Facilities Construction Program that has been in progress in the State since 1947. Perhaps some members of the medical profession are not aware that 33 new hospitals have been completed and put into operation since that program began in the State. The fundamental purpose of the Hill-Burton Act is to increase needed hospital facilities through Federal grants that would be matched by State or local funds or both. The language of the Federal act requires that preference be given in the construction of hospital facilities to those areas that have the fewest number of beds. In Georgia this

construction program has been the means of providing a number of hospitals in the smaller communities where unacceptable or obsolescent facilities have existed for many years.

From time to time photographs and reproductions of architects drawings of hospitals will be presented in this column for the purpose of keeping the physicians of the State informed as to the progress made in this program. These presentations will include hospitals which have been completed and put into operation in Georgia or that may be nearing completion and will soon be opened to serve the citizens of their area.

Bacon County Hospital
Alma, Georgia

Thirty beds Eleven Bassinets

This hospital was erected at a cost of \$329,000.00 and was placed in operation on December 7, 1952. It replaces the former Bacon County Hospital of eleven beds.





district and county societies

FIRST DISTRICT

1ST DISTRICT—Rosen, Samuel F., President, Savannah; Fulmer, Wm. H., Secretary, Savannah. Third Wednesday—March and July.
Bulloch-Candler-Evans—Deal, John Daniel, President, Portal; Deal, Albert, Secretary, Statesboro.
Burke—Butterfield, D. L., President, Waynesboro; Thompson, Cleveland, Jr., Secretary, Waynesboro. First Friday of each month.
Chatham—Morrison, H. J., President, Savannah; Osborne, Wm. W., Secretary, Savannah.
Emanuel—Brown, R. G., President, Swainsboro; Powell, C. E., Secretary, Swainsboro.
Jenkins—Lee, H. G., President, Millen; Mulkey, A. P., Secretary, Millen. First Friday of each month.
Montgomery—Kusnitz, Morris, President, Alamo; Palmer, J. W., Secretary, Ailey.
Screven—Hogsette, Gerald B., President, Sylvania; Freeman, James C., Secretary, Sylvania.
Tattnall—Hughes, J. M., President, Glennville; Pinkston, A. G., Jr., Secretary, Glennville. Second Wednesday, September and December.
Toombs—Finley, C. W., President, Vidalia; DeJarnette, R. H., Secretary, Vidalia.

SECOND DISTRICT

2ND DISTRICT—Jenkins, H. B., President, Donalsonville; Little, Frank A., Secretary, Thomasville. Second Thursday—April and October.
Brooks—Jones, A. B., Jr., President, Quitman; Wasden, Harry A., Secretary, Quitman.
Colquitt—Brannen, C. N., President, Moultrie; Fike, R. H., Secretary, Moultrie.
Decatur-Seminole—DuPree, Thomas E., President, Bainbridge; Ehrlich, M. A., Secretary, Bainbridge. Second Tuesdays—March, June, September, December.
Dougherty—Dunn, Robert, President, Albany; Russell, Paul T., Secretary, Albany.
Grady—Rehberg, A. W., President, Cairo; Rogers, J. V., Secretary, Cairo.
Mitchell—Hackett, L. E., President, Camilla; McNeill, A. A., Jr., Secretary, Camilla.
Thomas—Little, Frank G., President, Thomasville; Wine, Mervin B., Secretary, Thomasville. Third Wednesday—every third month.
Tift—Zimmerman, Charles, President, Tifton; Bridges, W. L., Secretary, Tifton. First Tuesday each month.
Calhoun-Early-Miller—Rentz, T. W., President, Colquitt; Lamson, Thomas H., Secretary, Colquitt. Third Wednesday—Bimonthly.
Worth—Tracy, J. L., Jr., President, Sylvester; Davis, H. G., Jr., Secretary, Sylvester.

THIRD DISTRICT

3RD DISTRICT—Robinson, J. H., III, President, Americus; Gatewood, T. Schley, Secretary, Americus. Third Thursday—April and November.
Ben Hill—Williams, W. D., President, Fitzgerald; Roberts, Ralph D., Secretary, Fitzgerald.
Crisp—McArthur, C. E., President, Cordele; Gower, O. T., Jr., Secretary, Cordele.
Dooley—Daves, V. C., President, Vienna; Malloy, Martin L., Secretary, Vienna.
Houston-Peach—Marshall, A. Smoak, President, Ft. Valley; Hendricks, A. G., Secretary, Perry.
Muscogee—Henderson, C. W., President, Columbus; Conger, A. B., Secretary, Columbus. Fourth Tuesday of each month.
Ocmulgee—Jones, Edward G., President, Eastman; Thomson, James L., Secretary, Eastman.

Randolph-Terrell—Ward, John A., President, Shellman; Martin, R. B., III, Secretary, Cuthbert. Second Friday of each month.

Suiter—Wilson, Frank A., III, President, Leslie; Fenn, Henry R., Secretary, Americus.
Taylor—Montgomery, R. C., II, President, Butler; Whatley, E. C., Secretary, Reynolds.
Wilcox—Harris, V. L., President, Rochelle; Owens, J. D., Secretary, Rochelle.

FOURTH DISTRICT

4TH DISTRICT—Kellum, J. M., President, Thomaston; Kinnard, George, Secretary, Newnan. Quarterly meetings. ...
Clayton-Fayette—Busey, T. J., President, Fayetteville; Sams, Helen F., Secretary, Fayetteville.
Coweta—St. John, James O., President, Newnan; Parks, J. W., Jr., Secretary, Newnan.
Henry—Ellis, H. C., President, McDonough; Foster, G. R., Jr., Secretary, McDonough.
Lamar—Crawford, J. B., President, Barnesville; Traylor, S. B., Secretary, Barnesville.
Meriwether-Harris—Chambless, Wm. G., President, Hamilton; Gilbert, R. B., Secretary, Greenville.
Newton—Paty, R. M., Jr., President, Covington; Palmer, Clarence B., Secretary, Covington.
Spalding—Oshlag, A. M., President, Griffin; Kelley, J. Welton, Secretary, Griffin. Third Tuesday of each month.
Troup—Mitchell, John T., President, LaGrange; Easley, Curran, Jr., Secretary, LaGrange.
Upson—Blackburn, John D., President; Thomaston; Gower, Wm. J., Jr., Secretary, Thomaston. First Tuesday each month.

FIFTH DISTRICT

5TH DISTRICT—Lange, Harry, President, Atlanta; Roberts, C. Purcell, Secretary, Atlanta. March and November.
DeKalb—Mendenhall, W. A., President, Chamblee; Leslie, John T., Secretary, Decatur. Second Monday—Sept., Oct., Nov., Dec., Jan.
Fulton—Hamm, Wm. G., President, Atlanta; Blalock, Tully T., Secretary, Atlanta. First Thursday—August, September, October, November, December, January.

SIXTH DISTRICT

6TH DISTRICT—Rawlings, Wm., President, Sandersville; Richardson, C. H., Jr., Secretary, Macon. Last Wednesday in June—First Wednesday in December.
Baldwin—Baugh, J. E., President, Milledgeville; Scott, Wilbur, Secretary, Milledgeville.
Bibb—Newton, Ralph, President, Macon; Tift, Henry H., Secretary, Macon. First Tuesday each month.
Hancock—Earl, H. L., President, Sparta; Tanner, David E., Secretary, Sparta.
Jasper—Belcher, F. S., President, Monticello; Lancaster, E. M., Secretary, Shady Dale.
Jefferson—Pilcher, George S., President, Louisville; Revell, Walter J., Secretary, Wadley. Second Thursday—Aug., Sept., Oct., Nov., and December.
Laurens—Anderson, R. T., President, Dublin; Kenney, Nell, Secretary, Dublin.
Monroe—Bramblett, A. Walker, Jr., President, Forsyth; Alexander, G. H., Secretary, Forsyth.
Washington—McElreath, F. T., President, Tennille; Helton, Wm. S., Secretary, Sandersville.

SEVENTH DISTRICT

7TH DISTRICT—Erwin, H. L., President, Dalton; Johnson, Ralph N., Secretary, Rome. First Wednesday in April—Last Wednesday in September.
Bartow—Howell, W. H., President, Cartersville; Dillard, Wm. B., Jr., Secretary, Cartersville. No scheduled meetings.
Carroll-Douglas-Haralson—Denney, R. L., President, Carrollton; Reese, D. S., Secretary, Carrollton.

Chattooga—Allen, J. J., President, Trion; Martin, Wm. P., Secretary, Summerville. First Friday each month.
Cobb—Burleigh, Bruce D., President, Marietta; Cauble, George C., Secretary, Marietta. First Monday—Sept., Oct., Nov., Dec. and Jan.
Floyd—Dellinger, R. W., President, Rome; Smith, Stephen D., Secretary, Rome.
Gordon—Steele, B. H., President, Fairmont; Richards, C. H., Secretary, Calhoun. Fourth Monday every other month.
Polk—Chaudron, P. O., President, Cedartown; Spanjer, R. F., Secretary, Cedartown. Last Tuesday each month.
Walker-Catoosa-Dade—Alsobrook, Thomas W., President, Rossville; Townsend, E. M., Secretary, Ringgold. Last Tuesday each month.
Whitfield—Boozar, A. M., President, Dalton; King, Hubert U., Secretary, Dalton. Third Wednesday each month.

EIGHTH DISTRICT

8TH DISTRICT—Pierce, L. W., President, Waycross; Harper, Sage, Secretary, Douglas. Second Tuesday—April and October.
Appling—Kennedy, F. D., President, Baxley; Brown, J. B., Jr., Secretary, Baxley. Second Tuesday of each month.
Coffee—Jardine, Dan A., President, Douglas; Harper, Sage, Secretary, Douglas. First Thursday each month.
Glynn—Towson, I. G., President, Sea Island; Hicks, J. N., Secretary, Brunswick.
South Georgia—Austin, G. J., President, Valdosta; Perry, R. L., Secretary, Valdosta. Second Tuesday—Oct., Nov., Dec., Jan.
Telfair—Mann, F. R., Jr., President, McRae; McRae, D. B., Secretary, McRae. First Monday each month.
Ware—Knight, Arthur, Jr., President, Waycross; Ferrell, T. J., Secretary, Waycross. First Thursday each month.
Wayne—Virusky, E. J., President, Jesup; Harper, Fred, Secretary, Jesup.

NINTH DISTRICT

9TH DISTRICT—Ward, E. L., President, Gainesville; Nicholson, George T., Secretary, Cornelia. April and September.
Blue Ridge—May, L. E., President, Blue Ridge; Hicks, Thomas J., Secretary, McCaysville. Second Thursday of each month.
Cherokee-Pickens—Hendrix, Arthur, President, Canton; Nich-

ols, Wm., Secretary, Canton.
Forsyth—Bramblett, Rupert, President, Cumming; Mashburn, James S., Secretary, Cumming.
Gwinnett—Kelley, D. C., President, Lawrenceville; Smith, R. E., Secretary, Buford.
Habersham—Henry, C. M., President, Clarkesville; Hicks, L. G., Jr., Secretary, Clarkesville. Third Thursday—each month.
Hall—Gilbert, Ben, President, Gainesville; Smith, Martin Henry, Secretary, Gainesville. First Tuesday each month.
Jackson Barrow—Rogers, A. A., President, Commerce; Moore, Lewis, W., Secretary, Winder.
Rabun—Neville, Lester, President, Dillard; Dover, J. C., Secretary, Clayton.
Stephens—Cleveland, P. B., President, Toccoa; Ayers, C. L., Secretary, Toccoa.

TENTH DISTRICT

10TH DISTRICT—Traylor, Bothwell, President, Athens; Schmidt, Donald W., Secretary, Lincolnton. Second Wednesday—February and August.
Clarke-Madison-Oconee—Greene, James A., President, Athens; Elder, John D., Secretary, Winder.
Elbert—O'Neil, J. B., III, President, Elberton; Mickel, C. A., Jr., Secretary, Elberton.
Franklin—Brown, Stewart D., Jr., President, Royston; Poole, E. T., Secretary, Lavonia.
Hart—Harper, George T., President, Dewy Rose; Cacchioli, Louis G., Secretary, Hartwell.
McDuffie—Riley, B. F., Jr., President, Thomson; LeRoy, A. G., Secretary, Thomson. Third Thursday each month.
Morgan—Dickens, C. H., President, Madison; McGeary, W. C., Secretary, Madison.
Richmond—Philpot, W. K., President, Augusta; Mulherin, J. L., Secretary, Augusta. Third Thursday—Sept., Oct., Nov., Dec. and Jan.
Walton—DeFreese, S. J., President, Monroe; Thompson, Ernest, Secretary, Monroe. Second Monday of each month.
Warren—Cason, H. B., President, Warrenton; Davis, A. W., Secretary, Warrenton.
Wilkes—Wills, C. E., Jr., President, Washington; Adair, M. C., Secretary, Washington.

Fulton County Medical Society Host to Southern Medical Assn.

Fulton County Medical Society will be the host to the 47th annual meeting of the Southern Medical Association in Atlanta October 26-29 at the Municipal Auditorium. The general chairman is Dr. Marion C. Pruitt and the Vice-General Chairman is Dr. W. A. Selman.

Other committees are as follows:

Executive Committee—Dr. William G. Hamm, Chairman; Dr. Marion C. Pruitt, Dr. William A. Selman, Dr. Olin S. Cofer, Dr. John W. Turner, Dr. Jack C. Norris.

General Sessions Program—Dr. Allen H. Bunce, Chairman; Dr. Thos. P. Goodwyn, Vice-Chairman.

Entertainment Committee—Dr. James H. Byram, Chairman; Dr. Mark S. Dougherty, Jr., Vice-Chairman.

Hotel Committee—Dr. Harold P. McDonald, Chairman; Dr. Bernard P. Wolff, Vice-Chairman.

Committee on Meeting Places—Dr. Shelley C. Davis, Chairman; Dr. Chas. F. Stone, Jr., Vice-Chairman.

Membership Committee—Dr. Carl C. Aven, Chairman; Dr. J. D. Martin, Jr., Vice-Chairman.

Golf Committee—Dr. J. R. Childs, Chairman; Dr. John J. Gerling, Vice-Chairman.

Committee on Publicity and Public Relations—Dr. Murdock Euen, Chairman; Dr. Stephen T. Brown, Vice-Chairman.

Committee on Scientific Exhibits—Dr. Phinizy Calhoun, Jr., Chairman; Dr. E. A. Bancker, Vice-Chairman.

Radio Committee—Dr. A. Hamblin Letton, Chairman; Dr. Tully T. Blalock, Vice-Chairman.

Alumni and Fraternity Dinners Committee—Dr. Edgar Boling, Chairman; Dr. Don F. Cathcart, Vice-Chairman.

Committee on Women Physicians—Dr. Amey Chappell, Chairman; Dr. W. Elizabeth Gambrell, Vice-Chairman.

Ladies Entertainment Committee—Mrs. Evert A. Bancker, Chairman; Mrs. Edgar M. Dunstan, Vice-Chairman.

Your JOURNAL-- Your RESPONSIBILITY

Each month your *Journal* is delivered to you with material slanted solely for your interests. Between its covers there are features, editorials, scientific articles, special articles, news of your Association activities, and personal items concerning your fellow physicians.

To print and publish this material is a very costly process. Five dollars of your annual dues pays for your year's subscription, but like most publications, the subscription revenue does not "pay the way" for your *Journal*. Stated bluntly, it is the advertising dollar that makes your publication possible. And without this revenue from the advertisers, the Medical Association of Georgia could not afford to publish such a *Journal* as you now receive monthly.

Increased production and printing costs within just the last year will have to be met by increased advertising revenue. It is obvious that advertisers receive benefit from their messages carried in your *Journal*. They are assured that information about

their product or service will "go" to almost every physician in Georgia. And as such, they are paying for service rendered. But it is important to also assure the advertisers that their message will not only "go" to the Georgia physicians, but will also be "read" by the doctors.

While the decision of what product or service to purchase is, as always, up to the individual physician—it would be well for the physician to remember those firms that through their advertisements in the *Journal*, support the *Journal*. Certainly they rate first consideration.

This consideration can be shown by reading their advertisement and by a courteous reception in your office of the firm's representative. Your purchase of a *Journal* advertised product or service; your cordiality to a *Journal* advertiser's representative is the best answer to a firm's support of your *Journal* with their advertising dollar. Trite, but still true is the phrase "support them, for they support your *Journal*."

Resolution--Memorial To

CHARLES

IVERSON

BYRANS, M. D.

The son of Iverson Brooks Bryans and Rebecca Turner, Dr. Bryans was born in Henry County, Georgia, on October 22, 1882. After graduating from McDonough High School he came to Augusta, where he entered the University of Georgia School of Medicine, from which he was graduated in 1904. Following a year's internship at Lamar Hospital, Dr. Bryans entered active practice and was appointed Assistant to the Chair of Surgery and Gynecology at the Medical College in Augusta, a position he held until 1918. Although prevented by physical disability from entering active military service during

Georgia recently lost one of her ablest and most respected physicians when Charles Iverson Bryans died July 18, 1953, at his residence in Augusta following a lengthy illness.

World War I, he served invaluable as medical examiner on the local draft board.

Having decided to limit his practice to the treatment of diseases of the eye, ear, nose, and throat, Dr. Bryans in 1918 pursued a course of study in this specialty at several New York hospitals. Upon his

return to Augusta, he received the Associateship to the Chair of Ophthalmology and Otolaryngology at the Medical College and in 1924 was made Clinical Professor in this department. He spent the summer of 1927 in Vienna doing additional study and work in his specialty.

The year 1933 saw Dr. Bryans' advancement to the head of the Department of Ophthalmology and Otolaryngology at the Medical College, a post he held until 1951, in spite of the fact that ill health forced his retirement from active practice in 1935. Upon his retirement as department head, he was made Emeritus Professor of Clinical Ophthalmology and Otolaryngology and held this position until his recent death.

Throughout all these years Dr. Bryans remained loyal to the Medical College and to the best interests of the University Hospital. Always his voice was raised in the cause of whatever was right, and he was quick and outspoken against anything that smacked of a violation of professional ethics or medical tradition.

He was a member of the Richmond County Medical Society; the Medical Association of Georgia; the Georgia Society of Ophthalmology and Otolaryngology; the American Medical Association; Alpha Omega Alpha, outstanding honorary medical fraternity; and Alpha Kappa Kappa, social medical fraternity. Dr. Bryans was a member of Reid Memorial Presbyterian Church. He was also a Rotarian and in point of service the oldest director of the Tuttle-Newton Home.

A man of skill and excellent judgment, beloved and honored by all who came under his care, he

gave of his time and strength to those in need without thought of compensation. Dr. Bryans was always interested in the charities and philanthropies of Augusta. Residents of the Widows' Home, the Mary Warren Home, and the Tuttle-Newton Home all knew his kindness and devotion to their interests and comfort.

Dr. Bryans is survived by his wife, the former Louise Keith Rowland, whom he married in 1918; a son, Maj. Charles Iverson Bryans, Jr., U. S. Army Medical Corps; a daughter, Mrs. Henry H. Claussen; and eight grandchildren. Other surviving relatives of Dr. Bryans include a brother and four sisters, all of Henry County.

In the death of Dr. Bryans this faculty has lost one of its ablest members; the medical profession has lost a competent and outstanding physician; his family has lost a devoted husband and father, and this community has lost a valuable citizen. His place in the home, upon this faculty, and in this community cannot be filled. Our sense of loss is nevertheless tempered by our knowledge of the contribution which he made to those things that are worth while.

This committee, appointed by the President of the Medical College of Georgia, offers this memorial to Dr. Charles Iverson Bryans as a resolution and moves that it be so adopted by the faculty; that it be recorded in the minutes of this meeting, and that a copy of this resolution be sent to the members of Dr. Bryans' family.

Dr. G. T. Bernard

Dr. Victor Roule

Dr. J. Righton Robertson, Chairman

Georgia Obstetrical and Gynecological Society

The Georgia Obstetrical and Gynecological Society was organized in May, 1951, at Macon. Annual meetings are held during the convention of the Medical Association of Georgia, wherein the Society functions as a sub-section of the state association. Interim meetings are held each fall at a time and place designated by the executive committee, and consist of morning and afternoon scientific sessions. The next interim meeting will take place in Athens on Friday, October 30th, 1953. Guest speaker at this meeting will be Dr. George W. Anderson, Associate Professor of Obstetrics, Johns Hopkins University.

The constitution of the Society, as amended May 13, 1953, provides for membership in two principal categories. (1) A member of the Medical Association of Georgia whose practice includes obstetrics and/or gynecology to an extent of fifty per

cent or greater is eligible for active membership. (2) Members of Medical Association of Georgia not eligible for regular membership are eligible for associate membership. Non members are cordially invited to attend any meeting of the Society.

Membership is by individual application for which forms are provided by the secretary upon request. Election of new members is held once yearly at the spring meeting. Delay in processing applications submitted during 1952 was occasioned by the fact that the membership committee was awaiting the completion of a constitutional amendment which changed the eligibility requirements as regards the active and associate status.

The original constitution restricted active membership to practitioners limited to the specialty, and provided associate membership for others. The purpose of this provision was to allow for subsequent

integration with the American Academy of Obstetrics and Gynecology which requires limitation of practice for membership. The Academy was likewise organized in 1951, and there was some possibility that within that organization state chapters might be established similar to those of the American College of Surgeons, American Academy of Pediatrics and others.

Subsequently the American Academy organized its geographic sections on a regional rather than a state basis with the result that no problem of integration arose. The constitution of the Georgia Society was amended as soon as possible to expand its active membership to a point more appropriate and more representative of the profession in Georgia. By deferring action during this period the membership committee was thus able to approve for active membership a number of applicants who otherwise could have been elected only as associate members. An explanation of the foregoing was obviously too involved for the previous secretary to have written

each applicant at the time.

The present membership of the Georgia Obstetrical and Gynecological Society is approximately 100. So far as the records show, all applications on hand prior to May, 1953, have been approved, the applicants elected to membership and so notified. It is hoped that any oversight will be called to the attention of the secretary. Any members of the Medical Association of Georgia desirous of applying for active or associate membership in the Society are invited to write the secretary for application forms.

Members of the Society are reminded that annual dues for 1953-1954 are now due, ten dollars for active members and four dollars for associate members. Make your checks payable to the Georgia State Obstetrical and Gynecological Society and mail to the secretary.

Hugh Bickerstaff, M.D.
President, Columbus
Eugene L. Griffin, M.D.
Secretary

For WHOM *The* SHOE FITS

It has been said that were an election held tomorrow, the American people would vote overwhelmingly for Governmental medicine. This, in spite of the money and effort expended by American physicians for better public relations; this, in spite of the best medical care in the world, this, in spite of the ever decreasing infant and maternal mortality rate; and the increased longevity of the American citizen. Indeed, in spite of everything that better physicians are doing to improve public relations and improve the health of Americans, we remain a vulnerable target for criticism.

For 10 years now with some degree of apology to ourselves and our fellow citizens, we have tried to overcome this criticism. How successful we have been is reflected in the opinion of the pollsters—an election now would bring socialized medicine. Why is it that while we offer our citizens the best trained doctors in the world, rapid advances in therapy and surgery and the myriad other advantages that the American system of medicine has produced, we have lost so many friends?

Is it true that we are wholly responsible for this attitude? Doctors and the medicine they practice must not be as bad as they have been portrayed in these past years of "pseudoliberalism." Has the American public received from the industrialist, the scientist and the physician more than he is equipped emotionally to intelligently appreciate? Is it emotional immaturity which is responsible for our ever

increasing rate of juvenile delinquency; the slaughter on our highways; the incredible divorce rate; and the mass of psychoneurotics?

Perhaps, and one thinks it safe to assume, that the advantages of the past 20 years have been too rapid for proper assimilation. Can it be that the emotional system has not kept pace with the products of man's intellect? The American has failed emotionally to measure up to the products of his intelligence. He has come full circle—from the childish devotion and adulation of the physician in the early 20th century to his present day attitude of distrust, rejection and antagonism. Somewhere between the favorable attitude of yesterday and the bitter criticism of today lies the attitude one would expect from an emotionally mature nation which has steadily increased its intellectual capacity for work. But before this antagonism is resolved much must be done. We physicians and our supporters know that we are correct when we defend our system of medical practice. Just as we learned to assist the individual patient who has little or no knowledge of the science of medicine so must we assist these same emotionally immature individuals to appreciate the American system of medicine. The emotionally mature and intellectually honest individual knows that the answer is not in Government medicine.

Editor's Note: While any situation is neither totally black nor white, this opinion is presented and does not necessarily represent the opinion of the *Journal*.—Editor.

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CORONARY INSUFFICIENCY or FAILURE

Disease of the coronary arteries causes two well known and widely separated clinical syndromes, angina pectoris and myocardial infarction. The diagnosis, prognosis and treatment of these two conditions is well known to the physician. Intermediate between these two entities, however, lies a vast and less well understood clinical territory. This intermediate clinical state is more severe and prolonged than angina pectoris; but, on the other hand it does not fulfill the recognized features of myocardial infarction.⁶⁻¹¹ The condition has been designated by both coronary insufficiency^{11-18, 20-23} and coronary failure.⁶⁻³⁻⁵ In order not to enter into the argument as to which is the preferable term, both will be used interchangeably in this article. Despite the fact that this condition has been adequately described in medical literature, there appears to be a reluctance on the part of many to make this diagnosis in the living patient and ascribe to it the cause of death in patients dying suddenly.

Of 199 cases of arteriosclerotic heart disease discharged from Crawford Long Hospital in 1951, only 18 had the subclassification "coronary insufficiency" added. At Grady Memorial Hospital, during the same period, 165 cases were diagnosed as arteriosclerotic heart disease; yet coronary insufficiency or failure was not specified in any case. Although the Georgia Bureau of Vital Statistics lists 3,486 deaths as due to "heart disease involving the coronary arteries" for the year 1950, not a single death was attributed to coronary insufficiency or failure. Failure to utilize either of these two terms may be due in part to the fact that the latest official diagnostic guide, published for the American Medical Association in January of 1952,²⁶ did not list either of these terms. In a corrected supplement to this guide, in August of 1952, "coronary insufficiency" was added.

There is sufficient evidence to support the view that coronary insufficiency or failure is a lethal condition. Yates et al,²⁸ reporting on 450 necropsies of servicemen between the ages of 18 and 39 years of age who died of coronary artery disease, found that 336 of the 450 died of coronary insufficiency

without gross myocardial infarction. Applebaum and Nicholson¹ found only 118 definite localized myocardial infarctions in 150 hearts of subjects dying of occlusive diseases of the coronary arteries. Wright-Smith,²⁷ in a series of 495 autopsies of patients dying from coronary obstruction, found only 87 or 17.6 per cent to have myocardial infarction. More than half of the 495 cases were symptomless until the fatal attack. Bean² found that 20 per cent of his 300 cases had myocardial infarctions without complete obstruction in the coronary artery involved. He adds; however, there was fibrotic narrowing, calcification, atheromatus abscesses or partial thrombosis, producing a permanent decrease in the caliber of the artery. He also said that, although "unpredictable sudden death has long been known as a frequent associate of angina pectoris and coronary thrombosis," he found no instance in his series where death followed coronary thrombosis in less than one hour and a quarter. Blumgart et al,⁵ in a joint clinical and pathological study of 125 cases, concluded that in general death occurs whenever a sufficiently large area of the myocardium undergoes ischemia, with or without necrosis, or when, because of ischemia, one of the following may occur: asystole, ventricular fibrillation, or congestive failure.

Disease of the coronary arteries, with resulting disproportion between the blood supply and the myocardial demand,¹¹ is the common etiological factor in the majority of cases of angina pectoris, coronary insufficiency and myocardial infarction. The differentiation between these three conditions is largely one of degree. They all have been shown to be capable of producing sudden death, and are therefore viewed with alarm by both the patient and physician. They may appear in the patient's history in orderly sequence or vice versa. They may produce varying degrees of ischemia, necrosis and fibrosis. The various clinical symptoms and findings are influenced by many factors such as: the pre-existing status of the coronary arteries and myocardium, the degree and duration of the myocardial ischemia, the resulting degree of necrosis or infarction, the rapidity and efficiency of intercoronary anastomosis, as well as others. Intercoronary anastomosis would seem to be a most important guide to the severity of the symptoms in coronary artery disease. Blumgart et al, in

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two detailed clinical and pathological studies of 125³ and 355³ necropsies, found that intercoronary anastomosis did not generally exceed 40 microns diameter in normal hearts; however, when coronary artery narrowing or obstruction occurred, there was regularly developed intercoronary anastomosis measuring from 40 to 200 microns in diameter. The authors concluded that anastomatic circulation develops when and where it is needed. They noted wide variation of the clinical-pathological relationship. Some had complete occlusion or considerable narrowing of one or more coronary arteries without giving rise to any clinical symptoms or signs and without producing myocardial damage. Yet, on the other hand, every patient studied, suffering primarily from angina pectoris alone and without evidence of other cardiovascular disease, had old complete occlusion of at least one major coronary artery. In another review of 532 autopsies⁴ on patients who in life had no signs or symptoms of heart disease and who died of other causes, 50 per cent had pathological evidence of coronary sclerosis. It has been estimated that approximately 50 per cent of the apparently normal male population over 45 years of age have significant coronary atherosclerosis; therefore, this sizable block of the population should be viewed as patients with chronic coronary disease from the standpoint both of treatment and prognosis.²⁴

The Differentiation of Angina Pectoris, Coronary Insufficiency or Failure and Myocardial Infarction

It is important to differentiate clinically the different types of coronary artery disease, for their prognosis and treatment varies accordingly. An accurate diagnosis permits individualized treatment. A patient with angina pectoris requires no formidable treatment. One with coronary insufficiency or failure certainly should not be subjected to undue anxiety and long costly periods of hospitalization or bed rest. Seven to 10 days rest and observation will usually suffice. On the other hand, the prompt recognition and treatment of this condition may forestall a subsequent myocardial infarction. Nor is it wise to adopt a stereotyped treatment for all cases of myocardial infarction. Mallory, White and Salcedo-Salgar,¹⁰ in studying the speed of healing myocardial infarctions in 72 cases, concluded that small infarcts are almost completely healed after five weeks, while large infarcts are completely healed or undergo no further discernible change after two months. Littmann and Barr,⁹ in discussing the differentiation between coronary failure and myocardial infarction, state: "It is just as unreasonable to regard a case of coronary failure as myocardial infarction as it would be to confuse a sprain with a fracture. The surgeon depends on an expertly made X-ray for the diagnosis of a fracture. The properly made and interpreted electrocardiogram is little if at all less specific." They also say that; although the electrocardiogram is the most accurate device we have for demonstrating myocardial disease, many clinicians dismiss it as another non-specific laboratory test when it fails to confirm their impression. Master and Jaffe¹⁹ state

that coronary occlusion and coronary insufficiency can be differentiated electrocardiographically in 95 per cent of their cases.

In the differential diagnosis of the different coronary artery syndromes, a detailed, precise and correctly interpreted history is essential. All of these syndromes have in common myocardial anoxia⁸ type of pain which is typically substernal in location and may or may not radiate to the neck, jaw, arms, and other localities. It is important to determine the frequency, duration, and intensity of the pain. The response to one of the rapid acting nitrates is also important, and this drug should always be available. Riseman and Brown,²⁵ in observing 87 patients during induced angina pectoris, found the duration of the pain to be less than three minutes in 97 per cent. Others feel that any pain which exceeds 15 to 20 minutes is probably not angina pectoris.

Coronary Failure

Freedberg, Blumgart, Zoll and Schlesinger⁷ describe the clinical syndrome coronary failure as follows:

1. There is prolonged severe cardiac pain lasting from one half hour to many hours, usually unresponsive to glyceryl trinitrate and rest. Patients often recognize that these episodes are different in quality and that the distress is commonly more intense and of longer duration than their attacks of angina pectoris.

2. Attacks are infrequent compared to the oft-repeated episodes of angina pectoris.

3. The attack may be provoked by exertion, emotion or other states in which the work of the heart is increased; but, they may occur during sleep or rest.

4. Evidences of myocardial necrosis, such as sustained leucocytosis and progressive elevation of the sedimentation rate and fever, are absent.

5. Electrocardiographic changes with the attack are either absent or minor. Rarely, transient changes similar to those seen with myocardial infarction may be present for a period of hours, with a subsequent return to the pattern before the attack. Progressive electrocardiographic changes of the type characteristic of acute myocardial infarction do not occur.

6. The blood pressure usually remains unchanged. Shock and pulmonary edema rarely occur.

CASE REPORTS

The following case is a typical example of coronary insufficiency or failure in a patient who subsequently developed transient congestive failure. He no doubt must have had some myocardial necrosis and during his convalescence probably developed collateral circulation. It would be interesting to follow his future course.

Case 1. J. L. P., age 33. A consulting engineer, with a negative past history. For the three months prior to admission he had noted dyspnea after climbing three flights of stairs. His work had been spasmodic and under pressure. For the previous thirty days he had worked especially hard and long hours.

On February 4, 1951, after eating a heavy meal and while playing bridge, he experienced short fleeting substernal pains, which increased in intensity and duration until the pain became constant and violent, radiating up into the substernal notch, left neck, shoulder, and down the left arm. His

CHART I.
TABLE OF DIFFERENTIATION

	ANGINA PECTORIS	CORONARY INSUFFICIENCY	MYOCARDIAL INFARCTION
Pain	Myocardial anoxia type and distribution. Usually associated with exertion or emotional excitement. Majority less than three minutes duration. Mild to moderate intensity.	Myocardial anoxia type and distribution. Usually associated with exertion or emotional excitement. Duration variable. Longer than angina. May be cyclic. Moderate to severe intensity.	Myocardial anoxia type and distribution. Majority not associated with exertion. Duration may be prolonged. May be cyclic. Severe, prolonged, crushing intensity.
Response to Nitroglycerine	Majority relieved.	May or may not be relieved.	Not relieved.
Shock-like State	Not present.	Usually not present.	Present in large infarcts.
EKG Changes	None to minor transient.	T Wave—RS-T Segment changes. Hours to days duration—more permanent if sub-endocardial necrosis exists.	T Wave—RS-T Segment changes—QRS changes—Q Waves occur—endocardial and pericardial changes. Patterns progress and may persist for weeks to permanent.
Fever	Not present.	Usually not present.	Present.
Inc. W.B.C.	No.	May be slight.	Usually increased.
Sedimentation Rate	Not increased.	Variable—usually not.	Usually increased.
Signs of Cong. Heart Failure	Usually not result of angina.	May or may not be present.	May or may not be present.

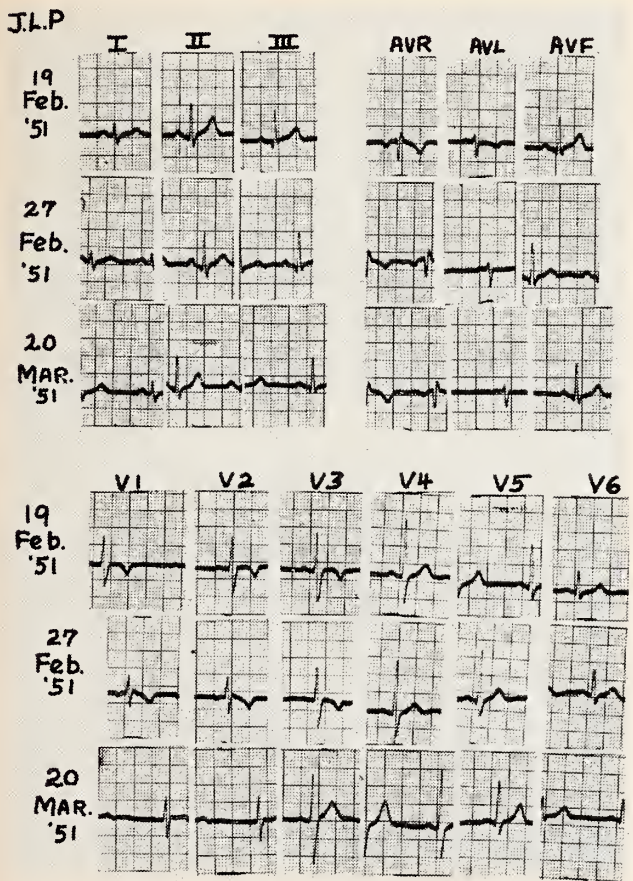
physician described his color as pale, but there was no excess perspiration or other evidence of shock. The blood pressure was 120/80. He was given 100 mg. of Demoral, which relieved his pain for one hour. Upon arrival at the hospital the pain recurred and he was given 100 mg. of Demoral intravenously, which again relieved the pain for another 45 minutes, only to recur less intensely, and this time it was relieved by Dilaudid gr. 1/32. He was placed in an oxygen tent. He vomited a large amount of undigested food. The physical examination was essentially normal. His color remained normal and the blood pressure stable. The admission white blood count was 12,400 with 84% polymorphonuclear leucocytes. He was placed on anti-coagulant therapy.

There was a gradual lessening of pain over the following few days. Repeated physical examinations were normal with the exception of a few crepitant rales over both posterior lung fields. The white blood count was 8,400 with 72% polymorphonuclear leucocytes on the sixth hospital day. Electrocardiograms done on the first, third, and sixth hospital days were essentially normal. Sedimentation rates done on the third and eighth hospital days were 8 and 9 m.m. per hour respectively. There was no elevation of the temperature, pulse, or respiration during his hospitalization. An X-ray of the heart and lungs done on the fifth hospital day was normal. Fluoroscopic studies of the heart, lungs, and barium filled esophagus were normal on the eighth hospital day. Fluoroscopic and film studies of the gastro-intestinal tract done on

the tenth hospital day were normal, with the exception of a diverticulum of the third portion of the duodenum. He was discharged from the hospital after 10 days to convalesce at home.

Several days after discharge from the hospital, while in bed at home, he developed angina decubitus and a gallop rhythm of the heart, inconsistently relieved by nitroglycerine, low sodium diet and mercurial diuretics. The angina suddenly disappeared after two weeks. He was then gradually allowed more exertion over the following two months. There was no return of the gallop rhythm and only minor, fleeting episodes of angina. Three repeated electrocardiograms and sedimentation rates over these two months were within normal limits. Three months after the onset of his illness another fluoroscopic examination of his heart and lungs was normal except for an exaggerated displacement of the barium filled esophagus at the aortic level. Over the next four months two additional electrocardiograms were unchanged from the previous tracings. He had returned to his former duties without symptoms other than noticing some diminution of his cardiac reserve. Another complete examination seven months after the onset of his illness was negative with the exception of some arteriolar spasm of the retinal arterioles, for which he was referred to an ophthalmologist for evaluation. At this period he was transferred to another city and contact was lost with the patient.

Figure 1. Serial electrocardiograms of Case No. 1. Electrocardiograms done on the first, third and sixth hospital days were normal and not included in the illustration. Transient inversion of the T waves occurred in AVL, V1, 2 and 3 in the tracings of the 19th and 27th of February 1951. These changes, probably indicating ischemia, had disappeared by March 20, 1951. Subsequent electrocardiograms taken one and five months later remained stable and were not included.



The following is an example of severe and prolonged coronary insufficiency or failure, producing extensive subendocardial necrosis and yet the electrocardiograms failed to fulfill the typical criteria of myocardial infarction. The patient developed cardiac enlargement and congestive failure and probably died of acute coronary failure.

Case 2. E. L. H., age 42. A barber, whose past history was negative except for the following. He was rejected from military service in 1943 for "Adult Maladjustment." For the past eight years he had been "very nervous." He had experienced insomnia for several years, averaging only four to five hours sleep unless he used hypnotics. He smoked 30 cigarettes per day. In 1950, he had pneumonia of three weeks duration, which was treated with aureomycin and penicillin. Six months prior to admission he began having almost daily squeezing substernal pain referred to both shoulders and down both arms, of only a few minutes duration and precipitated by exertion. He visited an internist who made an electrocardiogram and told him that his trouble was due to his "nerves." These pains continued for one month, then suddenly were arrested and he had no return for the following five months. Eight days prior to his first hospital admission the pains returned, more severe and frequent, lasting for 20 to 30 minutes, and usually occurring in the early morning soon after awakening, and also after emotional excitement or walking several blocks. He had noted dyspnea present during these episodes, but not so otherwise. For the most part, the pains were relieved by amyl nitrate; however, a few were

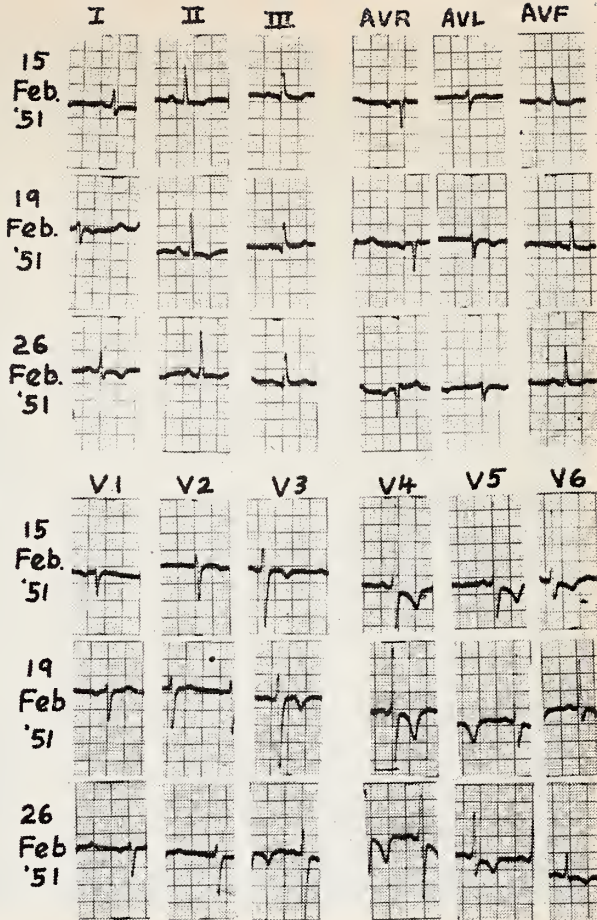
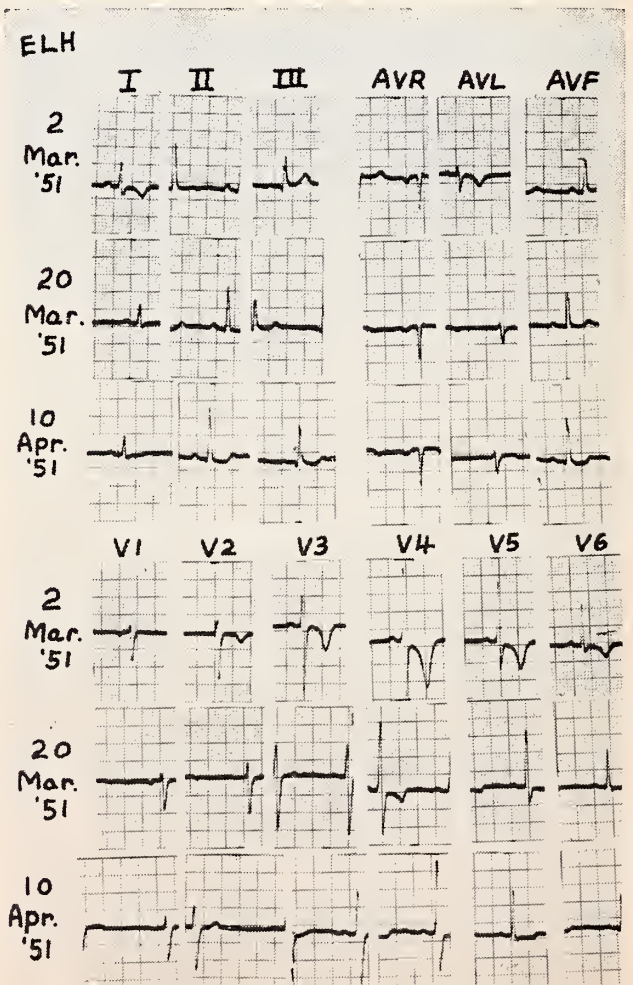


Figure 2A. Serial electrocardiograms of Case No. 2 are compatible with subendocardial ischemia and probably necrosis, but fail to fulfill the progressive changes of a posterior myocardial infarction.

Figure 2B. Serial electrocardiograms of Case No. 2. The Subendocardial ischemia appears to have reached its height by March 2, 1951 and then subsiding to and approaching normal by April 10, 1951.



so serve they required narcotics by his local physician for relief. They averaged from two to three episodes daily. He was admitted to the hospital February 15, 1951. The admission physical examination was essentially negative. The urinalysis was negative. The W.B.C. was 14,000 with 82% segmented cells. The electrocardiogram was compatible with subendocardial ischemia. During the following three weeks hospitalization he experienced numerous episodes of severe substernal pain not relieved by nitrates and on occasions not by the usual dosage of narcotics. On several occasions it was necessary to give 100 mg. of Demoral intravenously for relief. He developed a gallop heart rhythm and a few crepitant rales over his posterior and inferior lung fields. These disappeared and the pain was reduced in frequency and severity following digitalization and dehydration, with a low sodium diet and mercurial diuretics. He had no elevation of temperature, pulse or respiration, and no change in his blood pressure during his hospitalization. A sedimentation rate on the fifth day was 29 m.m. per hour. On the 11th day, it was 56 m.m. per hour, on the 15th day it was 75 m.m. per hour, and on the 20th day it was 71 m.m. per hour. His prothrombin time was maintained at therapeutic control levels throughout his hospitalization. Serial electrocardiograms done on the first, fifth, eleventh, and twentieth days were consistent with progressive subendocardial ischemia and necrosis; however, they failed to fulfill the criteria of typical myocardial infarction. The patient was very anxious and required as much as 15 grains of phenobarbital daily for relief and sleep. He was discharged after three weeks hospitalization to convalesce at home. Two weeks later he was seen in the office with a gallop rhythm and a slightly enlarged liver. He was given subcutaneous Thiomerin and oral Mercuhydrin. Twelve days later he was again seen. He stated he felt better and experienced only occasional anginal pains. He had been fishing and following his trade of a barber on a limited basis. Similar physical findings were present, but the gallop rhythm was no longer heard. Two subsequent electrocardiograms revealed less evidence of subendocardial ischemia and necrosis. The sedimentation rate, which was 71 m.m. per hour upon discharge from the hospital, was 51 m.m. three weeks later; 44 m.m. twenty days later, and 30 m.m. 30 days later. He was last seen in the office on May 25, 1951. He had lost five pounds due to anorexia. He felt worse, was back in bed approximately 50 per cent of the time and had experienced more anginal pains, which were relieved by nitroglycerine and amyl nitrate. The liver dullness was 13 c.m. Again a gallop rhythm was present. A fluoroscopic examination revealed a greatly enlarged left ventricle, together with enlarged right pulmonary vessels. No evidence of ventricular aneurysm was noted. He was given intramuscular Mercuhydrin. Resodac was added to his medication. He then began having more severe substernal pain requiring narcotics by his local physician, had more dyspnea and remained in bed. Nine days after he was last seen, he was again admitted to the hospital. His blood pressure was 134/100, a gallop rhythm was present, crepitant rales were present over the right posterior lower lung field. The liver dullness measured 13 c.m. He was having severe substernal pain and moderate cyanosis was present. He died suddenly 30 minutes after admission, while being placed in an oxygen tent. No autopsy could be obtained.

The following case of coronary insufficiency or failure was complicated by a respiratory infection and pulmonary emphysema and could easily be confused with myocardial infarction if one did not adhere closely to the typical criteria described for the latter.

Case 3. G. D. K., age 57. An executive, with a negative past history. He described irregular, vague, fleeting chest pains for several years. He had noted increasing exertional dyspnea for a few months prior to admission. The night before admission he had a dull aching pain in the back between the scapulae. He also noted a transient period of dizziness of 15 seconds. The morning of admission, November 2, 1951, he again experienced a dull constricting pain between the scapulae, which existed for two hours and then

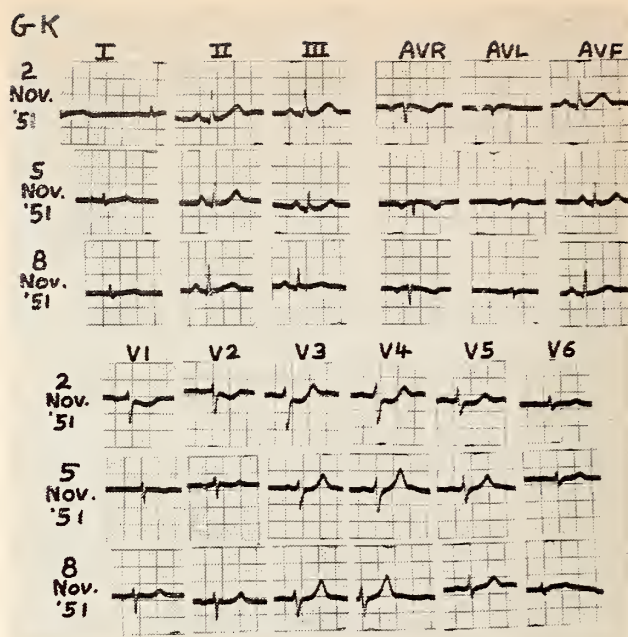


Figure 3. Serial electrocardiograms of Case No. 3. The first two tracings, of November 2, 1951 and November 5, 1951, resemble those seen in subendocardial ischemia and of course must be differentiated from posterior myocardial infarction by subsequent tracings. The abnormal changes however returned to normal by November 8, 1951. Subsequent tracings taken on the 14th and 26th of November as well as two months later remained normal and were not included in the illustration.

became substernal in location and continued for one hour before being transmitted up into the neck and down both arms. He fainted while walking a short distance to his physician's office. He was admitted to the hospital shortly thereafter. The physical examination upon admission was essentially normal, with the exception of evidence of pulmonary emphysema. The blood pressure was 138/80. There was no cyanosis. The pain was not relieved by nitroglycerine; however, 1/32 gr. of Dilaudil did afford relief. The temperature, pulse, respiration and urinalysis were all normal upon admission. The admission white blood count was 16,600 with 90% polymorphonuclear leucocytes. The electrocardiogram upon admission was compatible with either subendocardial ischemia or posterior myocardial infarction. For the following four days the temperature was elevated from 99° to 101°. A cough developed; however, no abnormal lung findings could be elicited by auscultation. Realizing that individuals with pulmonary emphysema may harbor pulmonary infections with minimal auscultatory and X-ray findings, penicillin therapy was initiated. The temperature was reduced to normal after 48 hours of penicillin therapy and remained so for the duration of the illness. The electrocardiogram, on the third day of his illness, demonstrated no evidence of injury and less ischemia than on admission. By the sixth day of his illness the electrocardiogram had returned to normal and another on the twelfth day of his illness was also normal, as have been subsequent tracings. The sedimentation rate on the fourth day of his illness was 70 m.m. per hour and on the tenth day was 100 m.m. per hour. An X-ray of the chest on the seventh day of his illness revealed only pulmonary emphysema and no evidence of active pulmonary infiltration. He was allowed to begin ambulation on the 12th day and was discharged on the 14th day. He was seen in the office one week later with no change in his symptoms or findings. The electrocardiogram was unchanged and the sedimentation rate was 11 m.m. per hour. He then spent the next month in Florida convalescing. Upon return he denied any symptoms of substernal pain, dyspnea, cough, etc. A fluoroscopic examination of the heart and lungs was negative. The electrocardiogram was unchanged. He was allowed to return to work.

The following is an example of a difficult differentiation between coronary insufficiency and a small myocardial infarction. The serial electrocardiograms favor the latter.

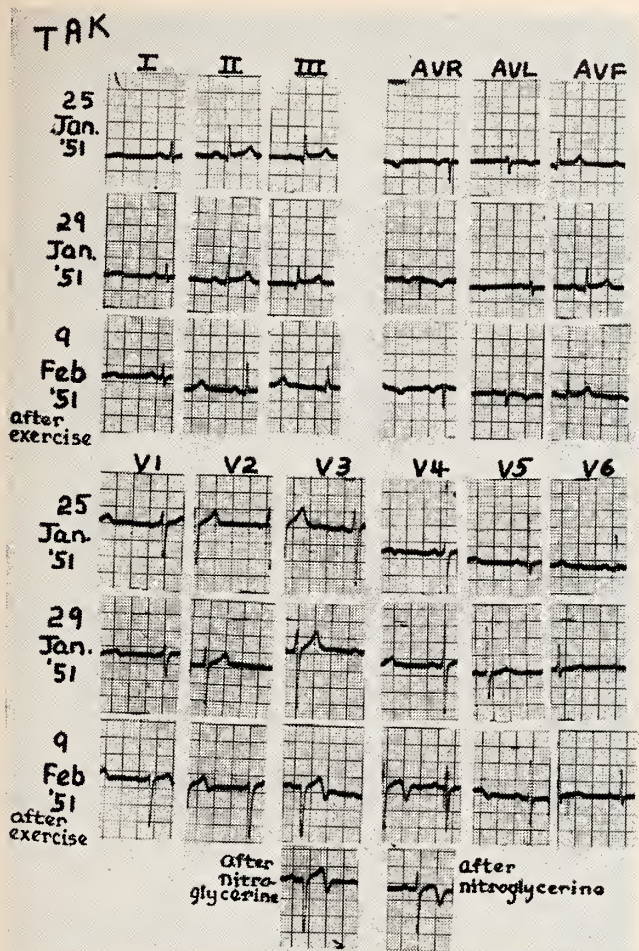


Figure 4. Serial electrocardiograms of Case No. 4. The tracings of the 25th and 29th of January 1951, produced no diagnostic findings, despite the frequent pains. After exercise on February 9, 1951, ischemic changes occurred in V 2, 3, 4 and 5. At this exact location typical changes of an acute antero-septal myocardial infarction, occurred one week later. Additional tracings revealed progressive changes which reached a climax by two weeks later, and then a return to normal two months later.

Case 4. T. A. K., age 42. Automobile assembly plant worker. First seen January 25, 1952. The past history was essentially negative except for a herniated intervertebral disc of L5 - S1, which was cured by an operation in 1947. He complained of increasing fatigue, dyspnea, and a substernal burning type pain upon exertion over the previous three weeks. A similar pain was relieved by nitroglycerine while he was in my office. Electrocardiograms and sedimentation rates upon the initial visit as well as four days later, were all normal. He was placed on partial bed rest for a week and then allowed gradual increasing activity. He was again seen February 9, 1951, because of a return of the above symptoms. A "Masters test" on this date reproduced the pain as well as positive electrocardiographic changes which did not return to normal after 15 minutes. A gallop rhythm of the heart was present on this visit. He was immediately hospitalized, placed at complete bed rest and on anticoagulant therapy. The admission white blood count was 12,000; differential 82% polys and 18% lymphs. The sedimentation rate was 10 m.m. per hour. There was no elevation of temperature, pulse or respiration during his hospitalization. The sedimentation rate rose to 20 m.m. on the 12th hospital day.

A gallop rhythm was noted on several occasions but was not consistently present. No other findings of congestive heart failure were present. The subsequent anginal pains were relieved temporarily by a low sodium diet, digitization and mercurial diuretics. Serial electrocardiograms demonstrated changes consistent with a small area of antero-septal ischemia and injury. He was discharged after two weeks and remained in bed at home an additional week. Having no more pain nor evidence of congestive heart failure other than an inconsistent gallop rhythm, he was allowed gradual ambulation. He was seen at two week intervals over the next two months, with gradual improvement in the electrocardiographic findings. He experienced an occasional mild attack of anginal pain, relieved by nitroglycerine and on one occasion he experienced rather severe angina just after he caught a rather large bass on a small fly rod. For the next two months he was seen at monthly intervals with no significant changes. A fluoroscopic examination failed to disclose any abnormalities of the heart or lungs. On June 23, 1952, he had moderate substernal pain radiating down the left arm, of two hours duration. Other than this episode he felt better, had less frequent angina and had gained several pounds. One month later he returned to his work. He had become very anxious concerning his heart and required considerable reassurance in order to convince him he was well enough to return to work five months after his initial illness. He has continued to work uneventfully since, with the exception of one episode of pain of 30 minutes duration on October 16, 1952. The pain originated in the left antecubital space, radiating up the left arm and over the precordium and was only partially relieved by nitroglycerine. The electrocardiogram on this date revealed no significant changes since the tracing done five months previously.

The following history demonstrates a condition which we frequently encounter. A patient who has a typical history of coronary artery disease, but who has repeated normal resting electrocardiograms. This man refused to be convinced that he had any pathology. It is another example of a patient having more confidence in what a gadget records, than in his physician's opinion.

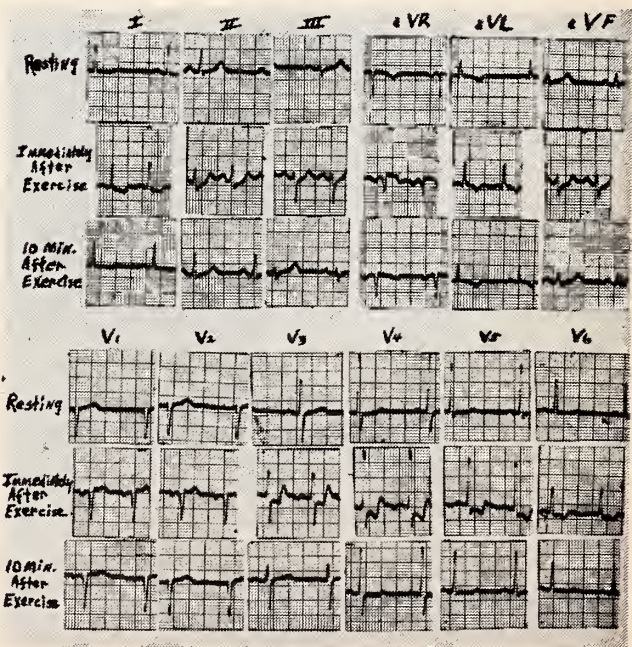


Figure 5. Serial electrocardiograms of Case No. 5. A normal resting electrocardiogram becoming markedly postitive immediately after exercise and returning to normal 10 minutes after exercise.

Case 5. J. V. R., was a 57-year-old male, who was district manager of an electrical appliance company. He gave a history of an episode of deep boaring anterior chest pain, filling the entire chest, radiating down both arms, of 48 hours duration. This occurred while he was away from home two years previous. A local M.D. visited him in his hotel, but did not perform diagnostic studies. Upon returning home his local physician obtained normal electrocardiographic tracings at that time as well as on many subsequent occasions. He experienced no more similar pains for the next six months. For 16 months prior to the time I first saw him, he had experienced almost daily angina pectoris. The pains occurred with exertion, under emotional stress and upon first arising in the morning or retiring at night. These pains had never exceeded 15 minutes in duration and were consistently relieved by nitroglycerine.

The fluoroscopic examination revealed an enlarged aorta and left ventricle. The "Masters Two Step" test, using the Cornell index for the prescribed exertion, produced a markedly positive test which may be seen in Figure 5, plus dyspnea and typical anginal pain. Three weeks after this test was done, this man experienced a typical antero-septal myocardial infarction.

This is a striking example of a patient who had proven coronary artery disease, who underwent an emotional crisis while being observed in the hospital, precipitating a temporary period of coronary insufficiency or failure, and being recorded on the electrocardiogram as myocardial ischemic changes. This should be additional evidence that the emotions are just as potent a factor as physical exertion in producing this effect in a given patient with coronary artery disease.

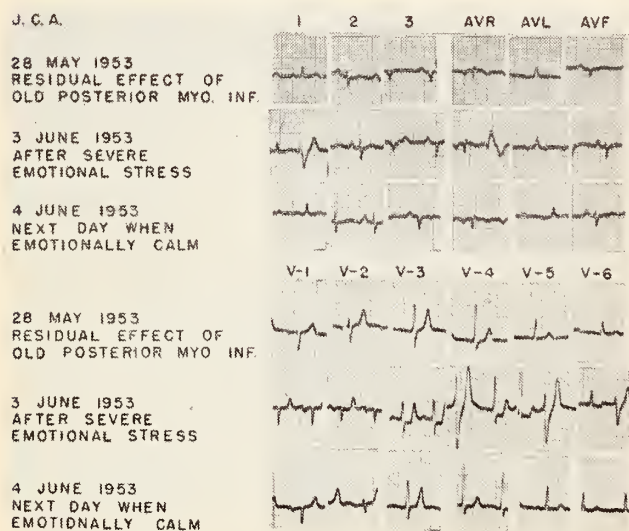


Figure 6. The first tracing May 28, 1953, indicates minor residual effects of his old posterior myocardial infarction. In the second tracing June 3, 1953, many premature ventricular beats are present plus S. T. Segment depression in V 3, 4, and 5. In the third tracing June 4, 1953, the premature beats have disappeared and the S. T. Segments are back normal.

Case 6. J. C. A., a 52-year-old male whose occupation was a Supervisor with the State Department of Education. This man had a proven posterior myocardial infarction 22 months prior to this admission. The interim had been uneventful on a moderation type regime, until three months prior to the present admission. At that time he began having frequent periods of anginal type pains with exertion and after eating a large meal. Electrocardiograms at that time were unchanged from those done 19 months previously.

He was admitted to the hospital May 28, 1953 following a five-hour period of substernal pain radiating down both arms, not relieved by nitroglycerine, and which required $\frac{1}{2}$ grain of morphine. The physical examination in the hospital was within normal limits. During his ten day hospitalization he had no elevation of his temperature, pulse, respiration, white blood count, or sedimentation rates. The admission electrocardiogram revealed only the residual electrical effects of the old posterior muscle injury. Four days later and at a time when he was severely upset emotionally because of a misunderstanding between the patient and a laboratory technician, an electrocardiogram was done. This tracing showed many premature ventricular beats and a rather marked depression of the S. T. Segments, in leads V 3, 4, and 5. The following day another tracing was taken. All the premature ventricular beats had disappeared and the S. T. Segment changes had returned to normal. These changes constitute the equivalent of a positive "Masters Test" indicating coronary insufficiency.

Summary

1. The need for the more frequent use of the diagnostic terms coronary insufficiency and failure is pointed out.

2. The differential diagnosis of this condition, angina pectoris, and myocardial infarction is discussed.

3. Several cases involving the different aspects of this condition are presented.

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DISCUSSION

DR. C. PURCELL ROBERTS (Atlanta): As we observe the natural history of coronary episodes, we are frequently confronted with this type of (so-called) coronary failure, not going on to frank occlusion and infarction. In this connection it is of interest to remember the paper of Reginald Fitz some years ago when, in discussing the effects of hypertension on the heart, he pointed out that a normal-sized heart in a hypertensive patient presupposes an adequate vascular tree. Conversely, the long-recognized "strain" pattern in the electrocardiogram of the hypertensive patient necessarily implies relative coronary inadequacy.

It is in this group of coronary patients that digitalis is more likely indicated. We have been aware that in pure anginal syndrome, (without cardiac enlargement and/or congestive events), exhibition of digitalis often increases angina. However, in the type of case under discussion, where there is more or less chronic coronary disease, digitalis (and/or mercurial diuretics) will often reduce the severity and frequency of anginal episodes.

We are rapidly making an about-face in our advice to cardiac patients about exercise. It has recently been pointed out that walking is of value in reducing hypertension. In the patient with angina of effort, of course, exercise tolerance may be attained only gradually, if there is natural remission or effective vasodilatation. But with coronary failure it is desirable to impose a physiological demand on the vascular system of the heart, by exercise to the point of tolerance. In this way the intercoronary anastomoses available will be utilized, engendering more adequate coronary reserve.

It is worth emphasizing, as Doctor Henry pointed out, that the recognition of this intermediate syndrome often provides a therapeutic opportunity. While we have not yet learned the constitutional or systemic approach for arresting the basic disease, management of the correctible or precipitating factors will frequently result in surprisingly good progress.

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PSYCHIATRY TODAY

SENILE AND ARTERIOSCLEROTIC PSYCHOSES

About twenty-seven percent of all new admissions to mental hospitals each year are patients with senile psychosis and psychosis with cerebral arteriosclerosis. Some feebleness of mind is characteristic of and normal for old age; it may be designated as senility or dotage. Arteriosclerosis is a natural concomitant of senility and in itself does not condition a psychosis unless marked. The time of its occurrence is largely determined by heredity and mode of living. Some persons inherit arterial tissue of low resistance. Even the ordinary wear and tear of living may exhaust the vitality of the vessels long before the conventional three-score-and-ten years. Old age is associated with many bodily infirmities; bones lose their dense structure, muscles become hypertonic, and the internal organs undergo a gradual atrophy. Joints are less flexible, tremor is often present, and vision is frequently clouded by cataract formation.

Neither arteriosclerosis nor the general atrophic process means serious senile mental impairment. The inability to meet stressing personal problems seems to be the crucial factor which leads to confusion and irritability in the older person. Arguments over property, fear of poverty, and unhappy home situations are the psychologic reasons behind many a senile agitation. Visual and hearing disturbances, some painful affliction, chronic infections, and failing circulation are frequent contributing factors.

The pre-senile period is especially noteworthy for the great prominence of depressions. These depressions are probably due to a failure of compensation at the psychological level. Conflicts with which the patients have been able to deal effectively break through and overwhelm them when the constructive forces begin to fail after middle life. The association of vascular changes and a decrease in the functional activity of the endocrine glands produce extensive changes in the chemical, metabolic, and vegetative activities of the body.

Cerebral arteriosclerosis may be a part of a generalized arteriosclerosis or may be largely confined to the cerebral vessels. Arteriosclerotic insanity occurs most frequently between the ages of fifty-five and sixty-five. Symptoms consisting of headache, dizziness, fainting spells, buzzing in the ears, a feeling of pressure in the head, and spots

before the eyes frequently are present. There is a gradual impairment of the capacity to think quickly and accurately, while interest in new objects and situations is no longer acquired. The patient's endurance is diminished and he tires much more readily than usual. Gradually disturbances of memory, especially for recent experiences, become more noticeable. Confabulations may appear but are rarely numerous. Also, probably a result of circulatory disturbances of the brain, there is a tendency to depression and anxiety. Anxiety states frequently develop. Mental storms, characterized by outbursts of excitability with periods of bewilderment, occur. Each attack leaves the patient more impaired. The emotions become progressively more labile. Ethical and finer sentiments are destroyed and childishness and obstinacy appear. The symptoms of deterioration are inconsistent. Correct judgments may be found side by side with defective and completely narrowed ones.

The maximum of cases of senile psychosis lies in the ages between sixty-five and eighty years and the disease occurs in both sexes about equally. Not infrequently acute debilitating diseases, such as pneumonia, occasion the outbreak. The normal regression of the brain begins in the early fifties. It does not become plainly noticeable until the last decade of the normal span of life. The earliest sign is a certain inability to assimilate the new ideas of others. The senile individual becomes progressively less interested in what goes on in the world. His thoughts are withdrawn to his more personal necessities. His feelings become more labile and he reacts to trifles. Besides excessive suggestibility one is struck by the stubborn intractableness. Not only impressionability but memory becomes poor. There is an inability to understand and recall new experiences and easy production of old memory material. Simple senile psychosis is an exaggeration of these symptoms.

As the first symptom there is often noticed a change of character; a sense of order develops into pedantry, firmness into stupid stubbornness, and economy into stinginess. The beginning of the condition is sometimes marked by sexual excitation in men who have been long impotent. There is an inability to understand and recall new experiences. The more recent an experience the sooner it is forgotten, until the last years disappear from the

memory, at first in part, later in their entirety. In the course of years the limits of recollection are pushed back farther and farther until the patients live in their childhood. Lively natures fill up the memory gaps with spontaneous confabulations; they tell fantastic stories of what they have accomplished. Many of these people do not like to say "I do not know," and invent an answer which they themselves believe. Because of their lack of judgment they can be misled into stupid financial transactions and uncalled for gifts. They are favorable materials for legacy hunters. The attempt to obtain the fortune is frequently made by way of marriage, in which case the heightened sexuality in many patients offers a good opportunity. Orientation is disturbed rather late, at first transiently at night, then also during the day. Patients frequently mistake day and night and in their nightly excitations want to go to their customary daily occupations. In the final stage, auditory and visual hallucinations are frequent. Many seniles, even those who are relatively clear, collect useless rubbish.

For the prevention of senile and arteriosclerotic psychoses elderly persons suffering from physical ailments should not be confined long to bed. The diet should be high in mineral content as decalcification of the bones is common in elderly people. Overeating should be cautioned against as it takes the circulatory system; with dilation of the vessels in the viscera after a large meal, the cerebral circulation is diminished. Senile individuals should be encouraged to continue their previous occupation but should not undertake too much. Changes of occupation and sudden complete cessation of work often leads to rapid deterioration.

In my experience, drug therapy or psychotherapy themselves have been ineffectual in the treatment of senile and arteriosclerotic psychoses. Patients with underlying depression, whose illness was of not more than six months duration, have been regularly treated with electric shock therapy, with excellent results in the majority of patients treated. Several patients with much confusion and paranoid delusions have shown considerable improvement with electric shock therapy. Delirious patients and patients with marked intellectual deterioration were excluded from treatment. Treatment is given twice weekly for a total of six to ten treatments. Patients are placed upon nicotinic acid, 50 milligrams three times daily, after meals, and therapeutic formula vitamin capsules twice daily after meals.

Mctrazol in doses of 1½ grains three times daily, after meals, is also frequently given. In the experience of this physician this drug has no demonstrable effect upon the psychosis but is of value in maintaining a state of well-being following recovery with electric shock therapy. Patients are given ascorbic acid, 1,000 milligrams and sodium niacinamide and thiamin hydrochloride, 200 milligrams each, intravenously several times weekly while under electric shock therapy. Patients receive psychotherapy at intervals of several weeks indefinitely after completion of shock therapy. It is my practice not to discharge these patients from under my care.

Senile and arteriosclerotic psychoses have proven to be complex reaction types in which psychologic, social, and economic factors play as great a part as the anatomic changes of an arteriosclerotic and senile degenerative nature.

HARRY R. LIPTON, M.D.

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DIAGNOSIS *of*

GALLBLADDER DISEASE"

Dr. Spalding Schroder: There is need for greater accuracy in the diagnosis of symptomatic gallbladder disease. Our chief concern today is twofold: (1) What symptoms may be correctly attributed to abnormalities of gallbladder function? and (2) In the presence of proper symptomatology, how can we improve our facilities to support the suspected diagnosis? The discussion will be limited to cholecystitis and cholelithiasis. The pertinancy of this discussion is attested to by two groups of patients: (1) the many people whose gallbladders are removed without relief of their symptoms, and (2) the smaller group of people whose gallbladders are not removed because the suspected diagnosis is not substantiated although the symptoms strongly suggest gallbladder origin.

Biliary colic is the most important symptom of cholecystitis as well as of cholelithiasis. There are many types of discomfort attributed to gallbladder dysfunction that are not true biliary colic, and these symptoms cannot be expected to be relieved by cholecystectomy, regardless of what the gallbladder x-ray study shows. Biliary colic is characteristically a constant, steady, slowly and progressively increasing pain, usually originating in the mid-epigastrium, and frequently remaining there. However, just as frequently it radiates to the right sub-costal area, and in recurrent attacks it may involve this area exclusively, or it may penetrate posteriorly to the right subscapular or to the interscapular area. Its most striking characteristic is its constancy. It is not cramping in character, nor is it gassy, as so many patients are prone to believe. It produces a sensation of severe soreness in the mid-epigastrium. Its intensity varies from very excruciating pain requiring narcotics for relief to a milder, annoying discomfort. It is not intermittent in character, like colicky intestinal cramps that have a crescendo and decrescendo pattern associated with peristaltic waves, but the pain of each episode is rather of a very constant character. That is what I mean by saying that its most striking characteristic is its constancy. A close analysis of the type of pain is by far the most important factor in establishing a diagnosis of biliary colic.

It may or may not be associated with vomiting. The outstanding physical finding is the presence of tenderness in the right subcostal area just medial to the midclavicular line.

The condition it mimics most closely is that of myocardial infarction, and many patients have been treated as having had one, two or three myocardial infarcts until the relationship to large meals, or fatty

Medical Conference

foods, or the frequency of onset of pain during the night, or the finding of a non-visualized gallbladder on x-ray has alerted the physician to the presence of gallbladder disease rather than coronary disease as the cause of the symptoms. The pain and soreness in the epigastrium may blend with pain over the lower substernal and thoracic cage area to the extent that myocardial infarction offers an extremely difficult differential diagnosis. This is quite different from the sticky or crampy or bloating sensations incorrectly attributed to gallbladder dysfunction.

The confusion of biliary colic with the pain of acute pancreatitis is classical, as borne out by the fact that when pancreatitis is diagnosed at operation, the preoperative diagnosis is usually acute cholecystitis. Operation may be necessary to distinguish between protracted biliary colic and cancer of the pancreas, especially if jaundice is present. It may usually be differentiated from peptic ulcer by careful analysis of the symptoms. The use of diagnostic x-ray studies, serum amylase determinations and serial electrocardiograms are invaluable aids in differentiating these conditions, when the results of these laboratory procedures are interpreted in the light of the carefully taken history and physical findings.

Acute cholecystitis is characterized by the symptoms of biliary colic combined with manifestations of

acute infection, resulting in an attack that is more prolonged, producing physical findings that last longer than would be expected in uncomplicated biliary colic. Chills may occur, and fever over 100° with leucocytosis is usually present. Physical findings are generally referable to the right upper quadrant and epigastrium with tenderness, muscle spasm and occasionally a palpable gallbladder. While jaundice usually indicates that a common duct stone is present, it may occasionally exist in the absence of an obstruction of the common duct. It is generally believed that acute cholecystitis is the result of mechanical obstruction of the gall-bladder and that bacterial invasion is secondary. While kinking of the gallbladder neck has been suggested as a potential factor in producing obstruction, it seems more likely that obstruction by biliary calculi is the usual cause of obstruction. The finding of stones in the gallbladder in 96 per cent of cases of acute cholecystitis¹ contributes to the validity of this mechanism. The complications that may occur include empyema, perforation, fistula formation, and liver destruction of varying degree as a result of pericholangiolitis.

Cholelithiasis has been estimated from autopsy statistics to occur in about 20 per cent of the population over age 40, and about three per cent of this group develop cancer of the gallbladder. Some 10 per cent of the population over age 40 are said to harbor

emory University Hospital

stones that produce no symptoms, while the remaining 10 per cent suffer symptoms related to the stones. It is important to recognize that the only discomfort that can be regularly attributed to the presence of gallstones is biliary colic, and that chronic dyspepsia between attacks of colic or dyspeptic symptoms without colic are not cholecystic in origin. The great number of patients whose symptoms of belching, bloating, gas, cramping and rumbling persist after cholecystectomy, attest to this truth. The physician should attribute these symptoms to their proper cause rather than to gallbladder disease, even though gallstones may have been demonstrated by x-ray studies. Complete diagnostic gastrointestinal studies are necessary to rule out other possible organic causes of these symptoms, but they usually represent variants of the irritable colon syndrome, such as the hepatic flexure syndrome, or at times they may be a result of aerophagy; but I wish to stress that they are not the result of gallstones nor of so-called chronic, non-calculous cholecystitis. Gallstones either produce biliary colic or they are silent. Chronic, non-calculous cholecystitis is a pathological entity, non-symptomatic, representing scarring produced by previous episodes of acute inflammatory episodes. It is non-symptomatic in the same way that chronic appendicitis is non-symptomatic. And its removal for the

relief of belching, bloating, gas and cramping sensations will offer the patient no relief from these symptoms.

Being thus forearmed with a critical appraisal of the history and physical findings, the clinician should now seek objective evidence of gallbladder pathology, always recalling that these aids must be interpreted in the light of his knowledge of the patient's history and physical findings. At this hospital we have felt that the really important objective diagnostic method available for diagnosis of cholelithiasis is the carefully performed gallbladder x-ray study. We have not used duodenal drainage for this purpose, but Drs. Napier Burson and Kerrison Juniper, working at the Atlanta V. A. Hospital, have had experience with this procedure, and I have invited them to give us the benefit of their experience.

Dr. Kerrison Juniper, Jr.: We would prefer to say that there are two objective diagnostic methods available for diagnosis of cholelithiasis—the gallbladder series and duodenal drainage. To accomplish duodenal drainage an intestinal tube is passed into the duodenum and gallbladder bile collected after local instillation of 33 per cent magnesium sulfate solution. The chief disadvantages of this procedure are the time required for the test and the necessity of a trained microscopist.

Diagnosis of cholelithiasis by this method is based on the presence of abnormal amounts of microscopic crystals in the gallbladder bile. The two chief elements found in stone are cholesterol crystals and calcium bilirubinate pigment. There is not sufficient time to go into the exact diagnostic picture in detail.

A review of the English literature revealed 1206 cases reported in sufficient detail to make an analysis if we accept the authors' statements that a significant number of crystals were present in each case. Seventy-six per cent of 642 cases of cholelithiasis and 73 per cent of 33 cases of cholesterosis were diagnosable by this technique.

Our experience with this test at the Veterans' Administration Hospital in Atlanta, Georgia, appears to parallel the above statistics. We grade our interpretations as far as cholelithiasis is concerned in the following manner: 1) diagnostic, 2) suggestive, 3) slightly suggestive, and 4) normal. We feel that when the picture falls into the first group, our accuracy is higher than 95 per cent. With the less definite interpretations, of course, the accuracy declines.

Duodenal drainage as a diagnostic test in gallbladder disease has been in use for over 30 years, and is still used by many gastroenterologists. We have found this procedure especially valuable in the following circumstances, for which we recommend its routine use:

- 1) When the gallbladder series is normal but history is suggestive of gallbladder disease;
- 2) In the jaundiced patient where interpretation of the gallbladder series is difficult;
- 3) Where Papanicolaou studies are desired because of suspected carcinoma of the liver, biliary tract, or pancreas.

Where the gallbladder series has been diagnostic

of stone, duodenal drainage would obviously be a waste of time. This procedure, however, is valuable to the internist because it is a test which he can perform himself.

Dr. Schroder: The report of 95 per cent accuracy in the cases graded in your first category would indicate that this is a valuable procedure and that more of us should become adept in the interpretation of specimens obtained by biliary drainage.

The use of cholecystography in arriving at an accurate diagnosis has simplified the problem considerably, but there are certain important aspects of this procedure that must be stressed. These will be discussed by Dr. James V. Rogers of the Department of Radiology of Emory University Hospital.

Dr. James V. Rogers: In order to appreciate the role of cholecystography in gallbladder disease, one must have a clear understanding of the physiology involved. The cholecystographic medium used in our department (Telepaque®) is given in tablet form with a fat free evening meal. Two ½ gram tablets for every 75 pounds of body weight is the usual dosage. The patient fasts until the radiographs are obtained the following morning between 8 and 10 a. m.

The medium is absorbed by the small intestine and excreted unchanged in the bile. The concentration of Telepaque® in the hepatic bile is so low that it is not visible on roentgenograms; however, it flows into the gallbladder where water is absorbed, and the concentration of Telepaque® is thereby increased to the point where it is easily visible on x-ray. This concentration may be attained as early as four to six hours; however, the optimum concentration usually is between 10 and 16 hours. From this it becomes apparent that if the gallbladder mucosa is sufficiently diseased, there will be no absorption of water by the gallbladder, with resultant inadequate concentration of Telepaque® for visualization. Such is the condition in acute cholecystitis, which is one of the causes of non-functioning gallbladder. The other common cause of non-functioning gallbladder is obstruction of the cystic duct, usually by a stone. Other causes of failure of visualization of the gallbladder are: 1) non-absorption of the contrast medium (vomiting, severe diarrhea, etc.), 2) severe liver disease with inadequate excretion, and 3) obstruction of the common duct. It may be possible to demonstrate the gallbladder in some cases of partial obstruction of the common duct with large dosages of contrast medium.

On the present day market, Telepaque® is the medium of choice because: 1) Infrequent side effects (nausea, vomiting, diarrhea, cramps, etc.) occur as compared with other media. 2) It has a higher iodine content and therefore greater radiopacity which increases the visibility of the poorly functioning gallbladder and the gall-bladder in obese patients. The

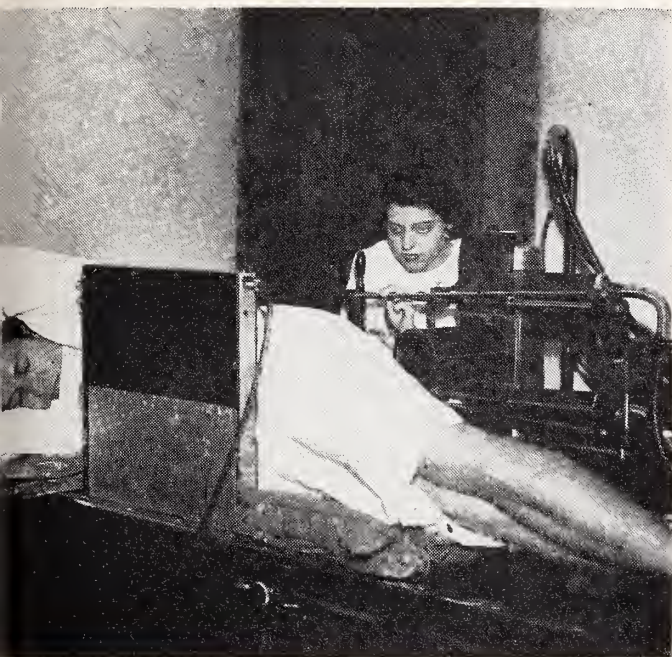
argument that it is less desirable because the increased radiopacity may obscure stones is not valid since the examiner may reduce the opacity if so desired by simply reducing the dosage of the contrast medium. 3) In nearly all cases there is an easily identified granular residue of Telepaque® in the colon which indicates that the patient has taken and retained the dye, and this gives one confidence in establishing the diagnosis of a non-functioning gallbladder.

There are several technical factors which must be given close attention if errors are to be minimized in cholecystography. These are: 1) The films must have good detail and be free of motion. If a small cone and Potter-Bucky diaphragm are used along with a short exposure time, films of good detail will usually be obtained. 2) A film study using a horizontal beam with the dependent part of the gallbladder projected free of confusing air shadows must be obtained in order to demonstrate small stones. For this projection we use routinely the right lateral decubitus position as described by Kirklin. (See Fig. 1.) It is preferable to the upright because in this position the dependent part of the gallbladder is nearly always free of air shadows, whereas in the upright, frequently air in the hepatic flexure overlies the gallbladder fundus. The importance of the position cannot be over-emphasized since stones in the gallbladder behave exactly as pebbles in a glass of water; that is, they sink to the most dependent part and in the usual prone position one is projecting the stones through the entire thickness of the opaque gallbladder bile. Tiny stones that form a uniform layer cannot be seen with usual prone position, and are seen only with the horizontal beam (decubitus or erect position) where they are depicted as a layer of diminished or of increased density in the dependent part of the gallbladder (See Fig. 2, 3) A repeat examination using double dose (not over 6 gm. of Telepaque®) should be performed in all cases with poorly functioning or non-functioning gallbladder. 4) Any doubtful examination should be repeated.

The routine gallbladder series in our department is a prone film with the patient in slight left anterior oblique position and a right lateral decubitus film. Following this a fatty meal is administered, and between 15 and 45 minutes later films employing the same positions are obtained.

If the cholecystographic examination is conducted carefully with these principles in mind the accuracy of the examination approaches 98 per cent correlation with surgical findings. Of the 50 patients having cholecystectomies at Emory University Hospital in 1952 on which cholecystograms were performed in our department, the surgical and radiographic findings coincided in all but one case. In this case stones were overlooked in a poorly functioning gallbladder. Retrospectively the stones were depicted in one roentgenogram in decubitus position; however, we misinterpreted the films since they were not seen on additional decubitus films. The explanation of this phenomenon is simple. If the specific gravity of the stones is very nearly that of the bile, it may take several minutes (about 5 minutes) for the stones to

Fig. 1. Right lateral decubitus position for cholecystography. A portable Patter-Bucky diaphragm containing a film is present in front of the patient and the tube is aligned behind the patient. Pillows are used to elevate the right side of the table.



settle out and if the film is made too soon after the patient is placed in decubitus position, they may not be seen because they have not yet layered out.

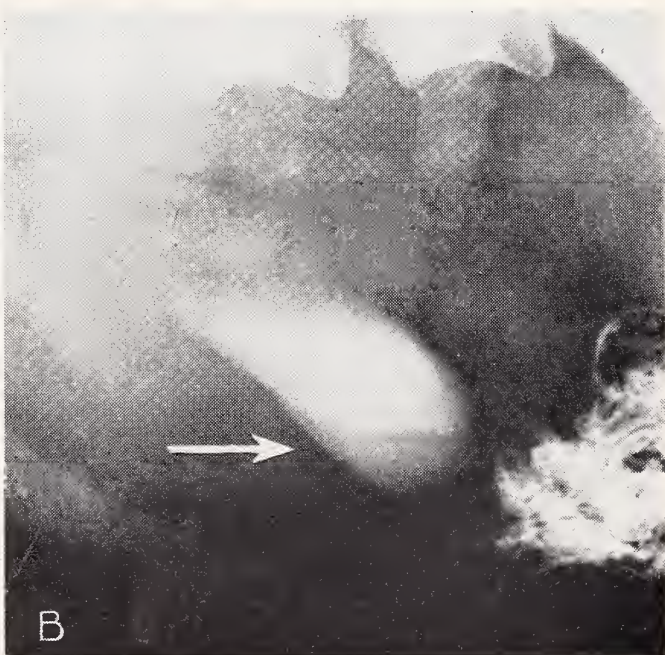
Dr. Schroder: When the diagnosis of acute cholecystitis or of symptomatic cholelithiasis has been made, the treatment is surgical, and Dr. Pat C. Shea, Jr., of the Department of Surgery at Grady Hospital, will now comment on certain of the surgical aspects of this problem.



Fig. 2. (A) Film study with patient in prone position with no interfering gas shadows. There is good concentration of the cholecystographic medium and no calculi can be seen.

Dr. Pat C. Shea, Jr.: In the presence of acute cholecystitis, as determined by clinical means, we prefer to observe and treat the patient conservatively, unless, of course, gangrene or perforation is considered imminent. As evidence of gangrene of the gallbladder wall one of the most valuable signs, in addition to the usual clinical manifestations is severe leucocytosis in the range of 25,000 to 35,000. There are several reasons for conservatism, and they are as follows: 1) Gallbladders rarely perforate, as is evidenced by the collected cases of Cole and Holden numbering some 2500. The highest rate of incidence of perforation are those data reported from the Jefferson-Hillman Hospital admissions 1930-1948 with nine free perforations in 985 cases of cholecystitis. In this group of nine "free" perforations seven deaths resulted: 2) The morbidity and mortality is increased in early surgery of these patients admitted with cholecystitis, and this is particularly true in individuals over 60 years of age; 3) When the diagnosis of cholecystitis is not clear cut, a period of conservative treatment and observation quite frequently makes a differential diagnosis more certain. One must be suspicious in this acutely ill patient of the possibility of myocardial ischemia or infarct, and peptic ulcer; the differentiation between either of these and acute cholecystitis frequently being difficult.

I would also like to make a few remarks about the "silent" or asymptomatic gallstone, namely those observed to be present on incidental x-ray examination, or cholecystography when performed in conjunction with gastrointestinal contrast x-ray examinations, or stones which are observed to be present at the time of exploration accompanying definitive surgery for other disease, e.g., hysterectomy, colon resection, etc. In our surgical service we elect to



(B) Film study on same patient in right lateral decubitus position showing layer of tiny radiolucent calculi.

perform cholecystectomy on all patients with silent stones because of their potentialities. To begin with, if observed early these people may have cholecystectomy performed with minimal risk at an elective period. If the patient later becomes symptomatic, he is apt to experience the pain and morbidity of repeated bouts of cholecystitis and the attendant complications; also, these increase threefold past the age of 60. The incidence of carcinoma of the gallbladder is greater in the patient with gallstones; over age 60 it is three times greater.

Wherever physicians gather to discuss gallbladder disease the question arises as to whether a grossly normal gallbladder should be removed. This consideration arises when patients are explored for suspected gallbladder disease. If the gallbladder appears normal, and there are no stones, it should be left in situ. It has been our experience that the more

severe the clinical evidences of disease, the fewer postcholecystectomy syndromes we have to deal with.

Failures occur after cholecystectomy for the following reasons:

- 1) Inability to remove the gallbladder because of technical hazards;
- 2) Injury to biliary duct structures;
- 3) Existence of long cystic duct and/or ampulla remnant;
- 4) Neuroma at the junction of common and cystic ducts;
- 5) Spasm of the sphincter of Oddi;
- 6) Biliary dyskinesia.

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THROMBOCYTOPENIA *and*

THROMBOCYTOMEGALY

in RENDU-OSLER'S *Disease*

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Rendu-Osler's disease, or Hereditary Hemorrhagic Telangiectasia, has been described⁴ as an hereditary affection manifesting itself in localized dilatations of capillaries and venules, forming distinct groups or telangiectases, which give rise to profuse hemorrhage either spontaneously or as the result of trauma. In typical cases it is recognized by the diagnostic triad^{3, 5} of: (1) hereditary tendency, (2) presence of visible telangiectases, and (3) tendency to bleed from these lesions. It has been repeatedly emphasized^{9, 11} that all studies for a hemor-

rhagic diathesis—such as bleeding time, coagulation time, clot retraction time, tourniquet test, and platelet count—are normal in this disease. These findings have been used in the differential diagnosis of the three conditions listed⁶ as the causes of familial epistaxis: (1) Hereditary Hemorrhagic Telangiectasia, (2) Pseudo-Hemophilia (von Willebrand's disease¹⁰), and (3) Hereditary Familial Purpura Simplex (of Davis⁷). In typical cases, these are differentiated as follows:

- I. Hereditary Hemorrhagic Telangiectasia:
Normal bleeding time
Normal coagulation time
Negative tourniquet test
- II. Pseudo-Hemophilia (von Willebrand):

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Prolonged bleeding time
Normal coagulation time
Variable tourniquet test

III. Hereditary Familial Purpura Simplex (Davis):
Normal bleeding time
Normal coagulation time
Positive tourniquet test.

We have recently studied nine cases of Hereditary Hemorrhagic Telangiectasia in one negro family⁷, and found moderate but definite thrombocytopenia in four of the nine. Thrombocytomegaly, with platelets averaging three to five times normal size, was also encountered in these four. In the others, the platelets were normal in both number and size. Since platelet counts are usually normal in this disease, and since the occurrence of large platelets has been mentioned⁸ only once in the literature, we consider the hematologic data in this family significant (see Chart 1).

The majority of reports of this disease either fail to mention the platelet counts or list them as normal. The following is a collection of platelet counts reported in the available literature of the past ten years:

Author	Platelet Count
1. Chevallier ¹²	272,000
2. Chevallier ¹³ , et al	432,000
3. Singer & Wolfson ¹⁴	220,000
4. "	250,000
5. "	325,000
6. Harding ¹⁵	73,000
7. Benko ¹⁶	180,000
8. Hedinger ¹⁷ et al	150,000 440,000
9. Desbuques ¹⁸ , et al	120,000
10. van Bogaert & Scherer ¹⁹	249,000 272,000
11. Cochrane & Leslie ²⁰	300,000
12. Barrock ¹	160,000

CHART 1

HEMATOLOGIC DATA IN FAMILY WITH RENDU-OSLER'S DISEASE

Pt.	Age	Hb	Rbc	Hct	Mch	Mcv	Mchc	Wbc	Diff.	Retics.	Sickling	Platelets	Comments
A.L.B.	13CM	11.5	4.56	35	25	76	32	7,200	N-29 E- 3 B- 1 L-60 M- 7	2.3%	neg.	606,480	1+ anisocytosis
J.A.B.	15CM	8.6	4.46	29	19	65	29	10,000	N-63 E- 1 B- 2 L-24 M-10	3.0%	neg.	240,840 large	occasional target cell 2+ anisocytosis 2+ poikilocytosis 2+ hypochromia
I.B.	9CF	8.6	4.34	29	19	66	29	8,000	N-53 E- 2 B- 1 L-40 M- 4	2.4%	neg.	194,300 large	target cells 3+ anisocytosis 2+ poikilocytosis 1+ polychromatophilia 2+ microcytosis and hypochromia
B.B.	11CM	11.6	4.42	36	26	81	31	7,700	N-39 E- 4 B- 1 L-52 M- 4		neg.	627,640	1+ anisocytosis
M.P.B.	42CF	9.5	3.72	32	25	86	29	5,350	N-46 E- 4 B- 1 Band-1 L-38 M-10	3.8%	neg.	137,640 large	3+ anisocytosis 2+ poikilocytosis 1+ polychromatophilia 2+ hypochromia target cells
M.B.P.	22CF	12.8	4.59	39	28	86	32	7,600	N-45 E- 3 L-50 M- 2	2.9%	neg.	867,510	1+ anisocytosis
D.J.G.	19CF	11.5	4.17	36	27	86	32	9,000	N-49 E- 1 L-40 M-10	1.8%	neg.	863,190	1+ anisocytosis
A.B.	16CM	7.7	4.37	29	17	66	26	4,700	N-43 E- 9 L-46 M- 2	4.0%	neg.	371,450	3+ anisocytosis 3+ poikilocytosis 3+ hypochromia few target cells
L.B.	12CM	6.4	3.47	24	18	69	26	5,500	N-49 E- 3 B- 2 L-41 M- 5	17.7%	neg.	190,850 large 130,000 136,000	4+ anisocytosis 3+ polychromatophilia 2+ poikilocytosis 3+ microcytosis 4+ hypochromia few target cells

13. Wells ²¹	470,000		
14. "	276,000		
15. Klinschmidt & Schwartz ²²	1,469,800		
16. Goldeck & Stiller	220,000		
17. Franke & Bindseil ²⁴	180,180		
18. Gambill ²⁵	114,000		
19. Kennedy ²⁶	290,000		
20. Moyer & Ackerman ²⁷	130,000		
21. Voyles & Ritchey ²⁸	126,000	187,000	
22. "	320,000	370,000	
23. Koch ²⁹	397,000		
24. "	86,000	170,000	247,000
25. "	360,000		
26. Wells ²¹	3,000	46,000	

Thus, thrombocytopenia has been reported in this disease before. Wells²¹ second case, a 40-year-old white female with epistaxis of nine years duration, had seven platelet counts between 3,000 and 46,000, and a consistently prolonged bleeding time. Stellar⁸ was the only author to note large platelets, but he did not comment thereon. One of our cases, who has had recurrent severe epistaxis with hepatosplenomegaly for the past eight years, has manifested rather consistent thrombocytopenia, usually ranging around 100,000-130,000. Since platelet counts are notoriously subject to inaccuracy, we employed an experienced technician, who had done over 200 platelet counts on normal individuals, to find that in her hands the normal range was between 500,000 and 1,000,000. She considers values below 300,000 definitely abnormal. Thus, four of our nine cases had definite moderate thrombocytopenia, and interestingly enough, thrombocytomegaly. (see Figures 1 and 2). These four individuals all had normal bleeding and coagulation times. Only one had enlargement of the liver or spleen.

Thrombocytopenia in this disease could be either an associated congenital defect, a sequel of hypersplenism, a result of chronic post-hemorrhagic anemia, or a coincidental finding. Since only one member of our family had hepatosplenomegaly, it is seen that thrombocytopenia can occur in the absence of splenomegaly. Likewise, it may occur in some members and not in others in one family. It is interesting that the four individuals with the lowest platelet counts had the most severe epistaxis. Win-

trobe¹¹ mentions low platelet counts in chronic post-hemorrhagic anemias. This has been considered in our cases. However, the finding of thrombocytomegaly raises the question as to whether or not this is an associated hereditary defect. It may be that thrombocytopenia and telangiectasia are related hereditary phenomena, and that in those inheriting both traits, the bleeding tendency is more marked. We feel that this question is unsettled but that it merits further study.

Conclusions

(1) Thrombocytopenia and thrombocytomegaly occurred in four of nine members of one colored family with Hereditary Hemorrhagic Telangiectasia.

(2) This has been noted previously but not emphasized.

(3) It is possible that the telangiectatic and the thrombocytopenic defects are associated, and that the transmission of both to an individual increases the tendency to hemorrhage.

(4) This problem merits further investigation.

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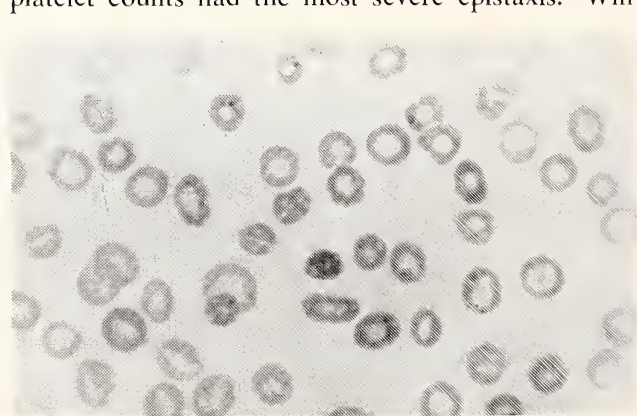


Figure 1: (L. B.) Blood Smear Revealing Large Thrombocyte, with onisocytosis, poikilocytosis, and hypochromia.

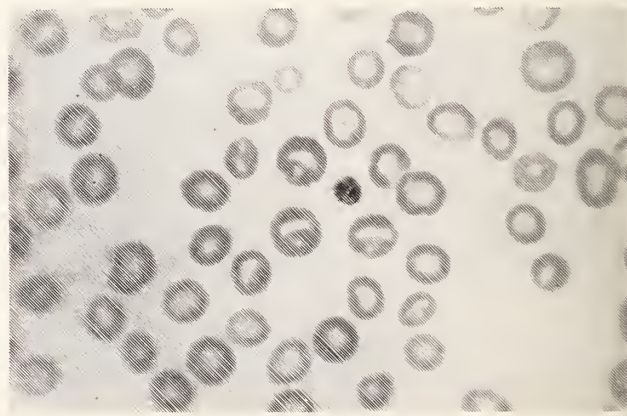


Figure 2: (I. B.) Blood smear from sister of above patient, showing same changes with a large platelet readily visible.

HYPERSPLENISM *with*

PANHEMATOPENIA *(Feltz's Syndrome)*

The following case is considered worthy of report because of (1) the relative rarity of Feltz's syndrome, (2) the neutropenia and leucopenia was much lower than in other cases reported, (3) pan-hematopenia existed, although the platelet level was never critical, (4) the patient survived many episodes of infection over a period of three years before splenectomy, (5) the marked general improvement following splenectomy and (6) the prompt return of the blood elements to normal levels where they have been maintained spontaneously since operation.

CASE REPORT

Mrs. M. C. W., a 52-year-old white married woman was admitted to the hospital March 20, 1948 complaining of an itching skin rash consisting of wheals and red, blotchy areas on the upper extremities, neck and chest. These skin lesions first appeared several weeks before her admission to the hospital and disappeared for a while after the use of Pyrabenzamine®. About two weeks prior to her admission this rash re-appeared, was quite extensive, caused severe itching, disturbed her sleep and made her quite nervous. She continued to take Pyrabenzamine® without relief. The rash came without apparent explanation.

System review was negative except for rapid heart action, shortness of breath and disabling arthritis. Tonsillectomy was the only operation. When she was 15 years of age she began having arthritis which has continued through her life with periods of activity and remission with progressive deformity of the joints of the hands and feet. There is no history of allergy. She has one daughter who is living and well. She passed through the climacteric without apparent difficulty. About 12 years ago she had marked exacerbation of her arthritis and it was found that she had a rather severe hypochromic microcytic anemia as diagnosed by Doctor Roy Kracke.

The physical examination showed a well nourished woman with a marked deforming arthritis of the hands and feet. She had a persistent tachycardia, the rate varying from 110 to 150. The blood pressure was 134/90. The heart, lungs and abdomen were negative. The spleen and liver were not noted as being enlarged. There was a typical urticarial rash on the forearms, neck and chest. The hands showed marked deformity with ulnar deviation. There was also a deforming arthritis of the toes. The temperature was 100.6°F. The clinical diagnosis was (1) urticaria—cause undetermined, and (2) rheumatoid arthritis.

Table number I shows the blood studies throughout the first hospital admission. A total of 22 blood counts were made with an average of 857 white blood cells.

TABLE I
Admission No. 1, March 20, 1948

Date	RBC	WBC	Hgb	Granulocytes	Lymphs.	Platelets	Misc. Sed. Rate 70 mm.
3-22-48	3,940,000	750	66.3/10.2	24	76		
3-23-48		400		20	80		
3-24-48	Red Blood Cells are very hypochromic						
3-25-48		450		16	84	132,000	
3-28-48		600		5	95		
3-30-48	In A.M.	500		10	90		
3-30-48	In P.M.	750					
4- 1-48		500		5	95		
4- 3-48		600		7	93		
4- 5-48		800		35	65		
4- 8-48		850		36	64		
4-12-48		750		6	44		
4-16-48		1600		14	85	1 unclassified	
4-22-48		1600		43	57		

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On March 24th, 1948 bone marrow studies were done by Doctor Darrell Ayer with the following report:

Differential	Per cent
Unclassified	1
Myelocytes	13
Juveniles	1
Bands	9
Segmenters	2
Normoblasts	17
Lymphocytes	66
Plasmocytes	1
Erythro-myeloid Ratio: 1:1.5	

1. Maturation arrest of granulopoietic series.
2. Hypoplasia of granulocytes.

The findings are consistent with those reported in many cases of agranulocytosis.

In view of the fact that this patient had chronic arthritis and that the diagnosis of agranulocytosis seemed likely, a careful survey was made to determine what medication she had been taking in the past several months. She had been given penicillin for an infection about six weeks prior to admission to the hospital. She had been accustomed to taking aspirin and empirin at irregular intervals and had taken Pyrabenzamine® daily for the past six or eight weeks for skin rash. She had been accustomed to taking mixed vitamins and iron. She had also taken seconal and phenobarbital for sleep at irregular intervals. Within the past few months she had taken Ertron and sodium salicylate for the arthritis.

A diagnosis of agranulocytosis was made and it was decided to give the patient 250 cc. of whole blood every other day. The patient continued to have fever which fluctuated from normal to as high as 102°F. daily. The treatment consisting of transfusions, crude liver and iron was carried on for several days with no increase in the number of white cells nor in the granulocytes. Then Pentnucleotide® was begun with 2 cc. being given intramuscularly twice daily and increased 2 cc. a day until 16 cc. was being administered twice a day. The patient then began to have rather sharp reactions to the Pentnucleotide® which consisted of aching, soreness, exacerbation of tachycardia and fever. Due to the fact that the patient was running so much fever the use of penicillin was begun. About four weeks after hospital admission the temperature and other symptoms began to subside and the patient seemed to improve. The leukocyte count increased to 1600 cells with 42 per cent polynuclear cells on the 22nd day of April and she was discharged on the 24th day of April and advised to take crude liver extract at home.

The final diagnosis for this period of hospitalization was (1) agranulocytosis, (2) chronic rheumatoid arthritis and (3) urticaria.

The patient was re-admitted to the hospital with a cellulitis of the plantar surface of the left foot on May 18, 1948 slightly less than a month after she was discharged. On admission this time her temperature was 99.2°F.; hemoglobin

68.9%/10.6 gm.; the white count was 500 with 4 per cent total polynuclear count and 96 per cent lymphocytes. The platelet count was 49,000. The red cells were 3,400,000. The urinalysis was negative. On penicillin therapy and rest the cellulitis of the foot subsided rapidly and she was dismissed from the hospital after seven days.

The next hospital admission was June 15, 1949 because of cellulitis of the right knee and thigh which had begun as a small infected pimple above the right knee. On admission to the hospital she had a pulse of 132 and the blood pressure was 130/90. The white cells numbered 900 with 14 per cent polynuclear cells and 86 per cent lymphocytes. The red cell count was 4,080,000 with 70%/10.9 gm. hemoglobin. The red cells were noted as being remarkably hypochromic. On bed rest, hot fomentations and large doses of penicillin this cellulitis subsided in a few days.

She was next admitted to the hospital on May 12, 1950 with bronchial pneumonia in the right lung. On this admission for the first time it was felt that her spleen was enlarged. On admission the red cell count numbered 3,870,000 with 66.3%/10.2 gm. hemoglobin and a white cell count of 800. The lymphocytes were 80 per cent and the polynuclears were 20 per cent. The platelets were noted as adequate. Her temperature on admission was 102°F. In eight days she had recovered on penicillin therapy.

In June, 1950 the patient had an acute ulcerative stomatitis with high fever which was treated successfully at home. She was not seen again until July 30, 1951 although she had several episodes of infection during this year which were treated at home with the use of penicillin. At no time did she go more than a few weeks without some infectious process requiring penicillin therapy.

On July 30, 1951 she was admitted to the hospital with a fracture of the neck of the left femur. Her temperature on admission was 100.2°F. The red blood cell count was 3,700,000; hemoglobin 68.4/10.5 gm.; the white cells were 450 with 93 per cent lymphocytes and 7 per cent polynuclear cells. The platelets were noted as adequate. She was given a general anesthetic and the hip was nailed. She was given large doses of penicillin and was discharged after a period of 10 days.

Table number II shows an outline of the laboratory examinations made in the second, third, fourth and fifth hospitalizations.

The patient had numerous infections throughout the rest of 1951 requiring treatment with penicillin. However, she recovered from the fracture and learned to walk. On December 16, 1951 she was admitted to the hospital because of intermittent fever fluctuating sharply and associated with weakness, sweats and tachycardia which had been present for the past several weeks.

On admission to the hospital the white blood cell count was 300 with 76 per cent lymphocytes and 24 per cent polynuclears; the platelets numbered 185,000. The hemoglobin was 63.3/9.6; the red blood cell count was 3,900,000.

TABLE II

Admission No. 2, May 18, 1948						
5-18-48	3,400,000	450	66.3/10.2			51,000
5-19-48			68.9/10.6			49,000
5-25-48		400		4	96	
Admission No. 3, June 15, 1949						
6-15-49	4,080,000	900	70.8/10.9	7	43	RBC hypochromic
Admission No. 4, May 12, 1950						
5-12-50	3,870,000	800	66.3/10.2	20	80	
5-17-50		600		20	80	
Admission No. 5, July 30, 1951						
7-30-51	3,700,000	450	68.4/10.5	1		Adequate

TABLE III

Admission No. 6, December 16, 1951

12-16-51	3,540,000	1,150	63.3/96	4	96	Adequate	Culture:
12-17-51	Malaria: Neg.	Sugar: 109	mgs.	Culture: No growth			No gr.
12-18-51	Agglutination series: Pos.	Typhoid H 1:80	Neg.	in all others			
12-22-51	Malaria: Neg.	Culture: No growth.					
1- 6-52	300			32	68		
1-10-52	7,500			74	26		
1-14-52	8,150			93	7		
	4,000,000	12,890	71.0/12.3	84	16	952,000	

Bone marrow studies were again done and reported as follows:

Disintegrated Cells	21	
Myeloblast	2	
Progranulocytes	3	
Myelocytes neutrophilic	30	
Myelocytes eosinophilic	5	
Myelocytes basophilic	6	
Metamyelocytes	11	
Bands	14	
Segmenters	4	
Mature Eosinophiles	2	
Mature Basophiles	1	Total Percentage 49.5
Lymphocytes	44	
Monocytes	2	Total Percentage 23.0
Mitosis	1	
Prorubricytes	3	
Rubricytes	5	
Basophilic	13	
Polychromatic	24	
Orthochromatic	7	
Metarubricytes	2	Total Percentage 27.5
Total No. of cells	200	100%

Summary: The marrow serves to rule out leukemia. It does not eliminate the possibility of agranulocytosis in a recovery phase, but the preponderance of granulocytes (myelocytes) favors hypersplenism.

Impression: Granulocytic hypoplasia.

A diagnosis of Felty's syndrome with hypersplenism was made at this time on the basis of bone marrow studies, a palpable spleen, history of recurring fever, the presence of rheumatoid arthritis and the persistence over a long period of time of anemia and neutropenia.

After consultation surgery was chosen as the treatment of choice and on January 3, 1952 a spleen weighing 680 grams was successfully removed.

On the 4th day of January, the day following splenectomy, her white blood count was 4200 with 68 per cent polynuclears. On the 6th day the white blood count was 7,500 with 74 per cent polynuclears. On the 14th day the white count was 12,800; red cell count was 4,000,000 and the hemoglobin was 79/12.3 and the platelet count was 952,000.

Since January, 1952 she has maintained a normal white count and has rarely had febrile infections. On May 6, 1952 her red cell count was 4,430,000; white count 5,300 and hemoglobin 91.0/14.0 with a polynuclear count of 7 per cent and 93 per cent lymphocytes.

Discussion

It has long been known that chronic rheumatoid arthritis affects the reticulo-endothelial system. Felty,² in 1924, reported five cases of rheumatoid arthritis associated with splenomegaly and neutropenia. In 1932 the spleen was first removed³ in a case of Felty's syndrome with satisfactory results. In 1939 Wiseman and Doan⁴ reported the first case of primary splenic neutropenia and in 1946 Doan and Wright¹ described hypersplenism and divided it into primary and secondary types. Felty's syndrome is

considered a secondary type of hypersplenism. The diagnosis of hypersplenism is predicated upon removal of the spleen and the return of the blood to normal values. In hypersplenism there may be a high degree of selective destruction of any one element of the blood such as granulocytes, the platelets or the red blood cells.

In rheumatoid arthritis hypersplenism occurs late in the disease. This patient gave a history of onset of rheumatoid arthritis at 15 years of age and the hypersplenic syndrome did not develop in her case until she was 51 or 52 years of age. Cases have been reported in which hypersplenism developed as early as five years after the onset of rheumatoid arthritis. This case is unique in that the degree of neutropenia and granulopenia was consistently greater than in most of the cases reported. I have not seen a case in the literature in which the granulocytes and the total white count were as consistently low over a long period of time as occurred in this case. This patient literally lived on penicillin from 1948 to December of 1951. She had repeated infection of the skin, mouth and respiratory system which responded to penicillin and had it not been for penicillin I do not believe the patient would have survived. She showed no response to any form of therapy instituted which included multiple transfusions, crude liver extract, iron, vitamins and Pentnucleotide. All the blood elements were depressed in her case and she consistently had a rather marked hypochromic anemia. The platelets were consistently depressed but never to a critical level and hemorrhage was not encountered. The patient did not show perceptible splenic enlargement until two years after the onset of the neutropenia. Fever occurred frequently in the three years that this patient was kept under observation. It usually was associated with evident infections but on many occasions particularly prior to the last hospitalization, fever persisted for several weeks without apparent explanation. Another striking feature of this case was the persistent tachycardia. This is still present although she has not had cardiac decompensation and there is no evidence of thyroid disease. During the entire period of time the patient had the difficulty with her blood, the arthritis was more or less painful and active. This patient has had for years a high degree of deformity of her hands with deformity of the feet and toes to a much less degree. She has been ambulatory even after recovery from the fracture of the hip but she walks with some difficulty. She maintained a good state of nutrition in spite of her illness. The hematological response to splenectomy was dramatic. The white blood count and platelet counts returned to

normal a few hours after splenectomy and have been maintained constantly at normal levels since. The granulocytes have never entirely returned to normal and have remained at 20 to 40 per cent since the operation. This patient's general health has improved greatly since splenectomy. She is ambulatory and is active in her home and community. At present she teaches a Sunday School class, is president of the garden club in her home town and is active generally in community life. While the arthritis troubles her at times it is considerably better than it was prior to the operation.

Summary

The case report of a 52-year-old white female who had suffered from rheumatoid arthritis for 37 years and who developed hypersplenism, hypochromic

anemia, neutropenia, leucopenia and a low blood platelet count associated with fever, recurring infections and marked tachycardia has been presented. Splenectomy was done with dramatic return of the white blood count, red blood count, hemoglobin and blood platelets to normal levels. The granulocytes have never returned to normal levels but vary from 20 to 40 per cent of the total white count. Marked improvement in the general health and in the chronic arthritic condition has occurred.

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HYDATIDIFORM MOLE *Following* INTERSTITIAL PREGNANCY

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Hydaticiform mole is a benign neoplasm of the chorion. It is probable that the original source of the changes present is in the ovum rather than in disease of the host, as indicated by the fact that twin pregnancies have been reported with one fetus normal and the chorionic villi of the other having undergone hydatiform changes.

Hydatidiform mole was formerly thought to be a degenerative rather than a neoplastic lesion, as such terms as myxoma chorii and cystic degeneration of the chorion indicate. "In his classic study of 1895, Marchand demonstrated that trophoblastic proliferation is the essential feature and this viewpoint is held by most investigators at present."¹

"Usually, no remnants of the fetus or of the amnion can be found; however, in other instances, such as those reported by Meyer, embryos and fetuses were seen in various stages of development."² The mole, then, may be considered a pathologic pregnancy with primary defect in the ovum.

Multiple bilateral lutein cysts of the ovary are frequently coincidental with the development of a mole. The nature of this association was not clear for a long time, and Williams said about them, "The fact that only a certain proportion of hydatidiform moles are associated with lutein cystomas speaks strongly against the assumption that the latter play an etiologic role. On the other hand, the demon-

stration by Fraenkel and Santi that such tumors undergo spontaneous involution within a few months after the expulsion of the mole, indicates that there must be some genetic relationship between the two processes."³

"Novak and Koff demonstrated that the hyperactivated anterior lobe of the pituitary, with excessive production of the luteinizing substance, is the immediate cause of the lutein hyperreaction seen in the ovaries of such cases. Thus, these cysts are definitely considered as secondary to the hydatidiform mole."⁴ Such extensive ovarian changes are not seen in normal pregnancy because such high levels of gonadotrophin are not maintained for such a period of time.

Hydatidiform mole usually occurs in women over 30 years of age and more often in multiparas. One of the earliest signs is a fairly persistent, brownish discharge which, at times, develops into actual bleeding, only to subside temporarily or to continue as a brownish excretion. This occurs early in gestation. These patients almost always experience severe nausea and vomiting and exhibit other signs of toxemia. The acute glycogen depletion from the maternal organism by such a rapidly growing mass of chorionic tissues has been suggested by Titus⁴ as the probable

mechanism of these toxic manifestations. Excessive production of gonadotropic substance usually occurs in patients having hydatidiform moles. Schoeneck¹ has shown that all patients having hyperemesis excrete higher than average amounts of gonadotropic substance in the urine. If Schoeneck's suggestion of such a hormonal cause of the vomiting of pregnancy is a tenable one, this should be an expected manifestation of hydatidiform mole. Its constancy in the presence of a mole certainly tends to lend support to the hormonal explanation.

It is of diagnostic importance that the uterus enlarges more than usual. Mathieu's comprehensive analysis,² however, showed a smaller uterus than expected in 10 per cent of the cases.

Digital examination or speculum exposure of the cervix may, but usually does not, disclose the typical grapelike or tapioca-like cysts of the mole, or the patient may describe or exhibit such masses that she has passed. This, of course, is conclusive evidence, but, unfortunately, is not often available.

Palpation and auscultation of the uterus abdominally are of only slight, if any, value. The doughy or cystic consistency of the uterus is not characteristic, while the absence of fetal heart tones usually does not indicate anything definite because the date of conception is generally too recent.

The utilization of the Asheim-Zondek test or the Friedman modification of this test for pregnancy in the diagnosis of hydatidiform mole as well as chorioepithelioma is an important item. Consequently, either of these tests may be utilized as a diagnostic measure on the basis of a quantitative reaction.

The concentration of anterior pituitary hormone in the urine in hydatidiform mole is almost always greater than that of a normal pregnancy, while with chorioepithelioma it is many times greater than the normal amount. For determination of this concentration, relative tests are most helpful. It is customary to test three rabbits with the same specimen of urine and to use different dilutions. The first animal is injected with the usual amount of urine (8 to 15 cc., depending upon specific gravity) used in testing for a normal pregnancy, the second with the same amount of urine diluted one to three parts, and the third with urine diluted one to seven parts.

The first animal is the first to be operated upon, and if the reaction is negative, the others are not inspected. If positive, the second animal's ovaries are checked, and if the reaction is also positive, the third animal is inspected. This procedure is entirely a relative one and gives results which must be viewed only in close conjunction with clinical findings. The second animal should show a definitely positive reaction with a mole; the third may or may not show a response. In chorioepithelioma, the third animal should give a sharply positive reaction.

Exceptionally, these reactions in hydatidiform mole will be negative. When this apparent paradox occurs, it is almost always the case that there has been more than the usual amount of bleeding, the uterus is smaller rather than larger than expected, and the mole has separated from the uterine wall and has a fibrinous or hemorrhagic capsule, although it

is firmly retained within the uterine cavity like a missed abortion.

REPORT OF CASE

Mrs. M. W., a 30-year-old white woman, was hospitalized because of acute pain of sudden onset in the lower portion of the abdomen some eight hours prior to admission. The pain was more generalized. She had experienced no nausea or vomiting. Nine months previously, she had been delivered at term spontaneously, and thereafter the normal menstrual cycle was resumed. The last normal menstrual period, six weeks prior to this admission, was two weeks late.

pain persisted from the onset, and by the time of admission Significant physical findings were confined to the abdomen and pelvis. The abdomen was slightly above plane, and a definite fluid wave was present. There was generalized tenderness, most pronounced in both lower quadrants with suggestive accentuation in the left lower quadrant. Pelvic examination revealed great tenderness, a soft bluish cervix, and fullness in the cul-de-sac and left adnexa. On admission, the temperature was 97.2 F., and the blood pressure was 100/80. Examination of the blood showed hemoglobin 63 per cent, red blood cells 3,150,000 and white blood cells 11,850, with 90 per cent polymorphonuclears and 10 per cent lymphocytes. A diagnosis of ectopic pregnancy, ruptured, was made, and an immediate laparotomy was performed.

At operation, the abdomen was filled with blood. The site of tubal rupture was at the left cornu of the uterus, which appeared to be the site of implantation, with rupture into the tube rather than into the uterine cavity. The left cornu and tube were removed. Both ovaries were normal. Pathologic examination confirmed these findings. The postoperative diagnosis was interstitial pregnancy. The patient was discharged from the hospital on the eighth postoperative day apparently in good condition.

Exactly five months from the date of this admission, she was again admitted to the Macon Hospital. In the interim, she had had no menstrual flow for 15 weeks after the operation; then there had begun a persistent mild flow, with two bouts of profuse bleeding, which continued until the time of readmission. At no time had she experienced pain or passed either clots or tissue. Two weeks prior to admission, she had consulted a physician and was told that she was probably some four months pregnant and threatening to abort. At that time her weight was 144 pounds, and the blood pressure was 108/70. She apparently was given an injection of some estrogenic substance, and then 25 mg. of stilbestrol daily by mouth was prescribed. Bleeding persisted.

On admission she did not appear acutely ill. Her weight was 155 pounds, blood pressure 140/90, hemoglobin 55 per cent, red blood cells 2,340,000, and leukocyte count normal. Urinalysis revealed the presence of 3 plus albumin, occasional red blood cells and white blood cells, and occasional hyalin, finely granular, and coarsely granular casts. Physical examination showed symmetric uterine enlargement to the size of a four and one-half month pregnancy. There was an odorless, dusty maroon vaginal discharge. The cervix was long and closed, was soft, and had a slightly bluish color. No tissue was seen either in the cervix or vagina. On the left side, posterior to the uterus, a very tender, firm mass about 10 cm. in diameter was felt. The presumptive diagnoses were (1) intrauterine pregnancy and pelvic tumor, (2) pre-eclamptic toxemia, (3) threatened abortion, and (4) anemia, secondary to loss of blood. The patient was given sedation, a toxemia diet, antibiotics, estrogens, intravenous magnesium sulfate, blood, and other fluids.

On the second day of hospitalization, there developed a severe, persistent headache and almost constant nausea and vomiting. The blood pressure at this time was 144/96, and urinary output was 20 cc. per hour. A roentgenogram of the abdomen showed a mass about the size of a five month pregnancy, thought to be uterus, but no fetal parts were seen. The possibility of a hydatid mole was considered, but discarded.

During the third and fourth days of hospitalization, generalized massive edema developed, the nausea and vomiting became more severe, and the urinary findings remained unchanged. The uterus became enlarged to about the size of an eight month pregnancy in a few hours, with no change in

vaginal discharge. Because of this fulminating toxemia, a decision was made to perform a hysterectomy.

At operation, the right ovary was under torsion, and on delivery of the uterus, it was disclosed that a large cyst had ruptured. Both ovaries were totally replaced by gestational luteal bodies and multiple luteal cysts. Proposed surgery was bilateral oophorectomy and hysterectomy. During resection of the right ovary, a tremendous uncontrollable hemorrhage was encountered, and rapid removal of both ovaries and supracervical hysterectomy were performed. Because of extensive laryngeal edema, a tracheotomy had to be carried out. It was not until the specimen was seen at the completion of surgery that the presence of the mole was known.

The pathologic report was as follows: "Specimen shows a uterus with gestational appearance of a near term pregnancy, containing about 1,500 cc. of vesicular hydropic hydatid mole. No evidence of fetal parts. Microscopic section shows marked papillary thickening of Langhans' layer, with interstitial edema of the syncytium. There is rather remarkable proliferative overgrowth of the trophoblastic elements, particularly within the myometrium. The deeper muscularis is not invaded. No evidence of malignant transformation."

After a stormy immediate postoperative course, the patient recovered and was discharged on the thirteenth postoperative day in good condition. Complete physical exami-

nation six weeks postoperatively showed her to be in good health.

Summary

A case is reported in which interstitial pregnancy was followed after five months by an operation for hydatidiform mole.

Whether the mole was a residual of the abnormal implantation present at the time of the first operation or was a subsequent pregnancy remains a question.

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To say that the journal of a state medical association is as good as its editors is also to say that it is only as good as the material the members provide for their utilization. No matter how well it is staffed and managed, no matter how attractive its format, its success obviously depends

The SUCCESSFUL

State Medical JOURNAL

SHALER RICHARDSON, M.D.*, Jacksonville, Fla.

primarily on the subject matter provided by the members.

The *Journal of the Medical Association of Georgia* is therefore your journal, not merely from the standpoint of ownership but also from the standpoint of contributions. It reflects you, individually as well as collectively. Has it been a better publication this year because you have made a worthy contribution to it? Or could it have been better had you not failed it?

Scientific Articles

The quality of its scientific articles is a gauge of professional progress which, above all, determines the rating of any journal as a medical periodical. Certainly the writing and publication of medical articles form an indispensable adjunct to the medical profession and a fundamental aid in its advancement. The well prepared paper is always acceptable if it is opportunely timed and presents a practical subject.

New scientific evidence is ever welcome, regardless of how much the subject to which it pertains may have been discussed. The basis for a good article may lie in original experimental work, the report of an interesting case, or the presentation of a clinical note or helpful suggestion. What general practitioner does not glean some unusual information from time to time which should be shared with his colleagues? And, likewise, what specialist? Even with his state journal conveniently at hand as an appropriate channel, he nevertheless too often fails to disseminate the helpful information. Every member of your association should be, and doubtless is, urged to send in scientific articles for publication.

If the material has merit, the faults of a manuscript may be remedied. The importance of careful, competent medical editing cannot be overemphasized. Aside from subject matter, nothing that I

know of lends prestige to a medical publication as does proper editing. Here is an investment which gives tone to a journal and also brings other returns. It is both surprising and gratifying to notice over a period of years how good editing pays off in improved preparation of papers submitted. While contributors are not expected to be finished authors versed in journalistic usage, it has been my observation that the papers submitted from year to year reflect more and more the educational value of consistent capable editing. Also, they carry more weight with the reader than if they were published in carelessly prepared form. Editing is a responsibility of the journal itself, not the author, and a service every author should welcome and appreciate. Every journal should seek and take pride in as expert editing service as it is possible to obtain.

During a quarter of a century of experience as editor of the official publication of your sister association on the south, I have learned long since what your able editor, Dr. David Henry Poer, is finding out. Editors do indeed have their trials and tribulations, but they find that there are compensations, many and varied. One at which I never cease to be astounded is the number of inquiries and comments received from the far corners of the earth. Frequently, requests for reprints come from foreign countries. Our most recent foreign subscription came from Australia, and we have paid subscriptions going to Canada, England, Germany, Italy, Africa and elsewhere, as you doubtless do, too.

Interest from abroad centers on the more highly technical papers, particularly those publishing results of research. These same articles have widespread appeal in this country also. Occasionally, there are papers with special popular appeal because of the very nature of their subject matter. No less scientific and frequently involving intensive study and research, they nevertheless command the attention of newspapermen and free lance science writers. Our most recent examples of this type of paper were on dermatologic dangers of sunlight and baby feeding. The next time you are tempted to belittle your

Editor, *Journal of the Florida State Medical Association*.

Read before the Editorial Board, *Journal of the Medical Association of Georgia*, 103 Annual Session, Savannah, May 11, 1953.

state journal as provincial, remember that its reader scope is not only national but international. Then set about helping to make it worthy of its broad mission.

Abstracts

A particularly worth while feature of a state medical journal, in my opinion, is an abstract department. Members of a state society whose articles are published outside the state deserve recognition in their own journal, and a brief digest of the articles keeps their fellow members abreast of their writings, enabling those interested to obtain reprints. All members of the Florida Medical Association are urged to send our journal reprints for abstracting. In addition, the staff checks all medical periodicals received in an effort to find every article published by a member.

As with editing, abstracting is a painstaking procedure to be carried out preferably by a member of the staff specially trained for the purpose. No abstract should be published, however, without previous signed approval of the author of the article.

Editorials and Commentaries

Reader interest may be enhanced by a strong editorial section—not partisan and controversial, but forthright and stimulating, dealing with subjects of vital interest to the medical profession. Certainly, an editor needs to be wary at this point, but common sense and good judgment can make of this department a valuable asset. To assistant and associate editors it offers an outlet for latent editorial talent, and a trained editorial writer on the staff is a great help.

Here, too, the reader may look for a preview of important gatherings and mention of various events and trends of which there should be a permanent record. In Florida, historical events of medical interest have won wide reader appeal in these columns. The state journal has an obligation to the past, the present and the future, which may be well discharged in this section.

News Items

News items make up a popular section always, but frequently they are not too readily obtained. Perhaps we are all too well schooled against free personal advertising, or are just innately modest. This is, however, an informal column which should contain only items of medical interest, not those pertaining to pleasure, sports events, social gatherings or family travels. Acceptable items relate to postgraduate studies, visits to clinics and hospitals, addresses on medical subjects, military service assignments, and office or committee assignments. Births, marriages and deaths are items accorded special separate treatment in many journals.

In some county medical societies there is a news reporter whose duties include sending in items; in others, the secretary sends them in. Other sources are a newspaper clipping service and county medical society bulletins. It would be most helpful however, if each member would consider himself a committee of one to send in at any time personal medical news items of interest to the entire membership. Undoubtedly, Dr. Poer would be as gratified as I for such cooperation.

Component society notes also have sectional reader interest. This feature should be encouraged, for it can be only as complete as the individual societies make it.

Other Features

Sections devoted to the Blue Shield, State Board of Health, Books Received, Correspondence and the Woman's Auxiliary all have their place in a state journal. Another function of such a publication is to make readily available a list of association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of the county societies with their presidents, secretaries, meeting dates and current membership.

Often a President's Page is an effective feature. It reflects the personality and thinking on affairs medical of the association's highest official and brings the leadership and the association as a whole closer together.

I would put in a special plea for the cooperation of necrology committees of the county societies in obtaining and transmitting to the state journal accurate and complete information for preparing obituaries. This delicate and difficult task is often hampered by lack of information that could be obtained locally with a little effort. In the interest of a correct permanent record, this final service to our fallen fellow members seems not too much to ask and expect.

Much might be said on the technical side about the value of an attractive format, the appeal of a readable table of contents and the value of a comprehensive index covering each 12 months period. Certainly your own *Journal* is an excellent example of eye appeal.

District Meetings

It has been my custom through the years to visit the district meetings each fall and present the work of our journal personally at these gatherings. This method of keeping their journal before the members has proved worth while. A journal display is also helpful on such occasions and at the annual meetings.

Finances

We now come to a phase of publishing a medical journal which is of no small concern, particularly to the editor and managing editor. No doubt, you are interested to know whether our *Journal* is self-supporting. Frankly, the answer is "no", however, an analysis as to "why" is not quite so simple.

In processing the *Journal*, we endeavor to be as economical as possible. For that reason, we do not get involved in detailed cost accounting. That would only add to the expense. Most of our revenue, naturally, comes from display advertising. A very small amount is received from classified ads. Essentially all our national accounts are handled, as are yours, by the State Journal Advertising Bureau, sponsored by A.M.A. We do carry a few, direct, local accounts. Revenue from advertising just about defrays the cost of printing and paper stock.

There are two factors in particular which complicate accurate determination of publishing costs. First, each member receives his subscription to the *Journal* as a part of his dues. What value should be placed

on a member's subscription? Second, our *Journal* is processed in the executive office by the same employees who handle the other affairs of the Association. No employee devotes his time exclusive to the *Journal*. Thus you see it would be very difficult to determine how much of each employee's time should be charged against the *Journal* without adding heavy bookkeeping expense.

Minor sources of revenue include subscriptions to non-members, institutions, commercial firms and honorary members.

Obviously the better the *Journal*, the more appeal it has to advertisers. Also, keep in mind that advertising rates are based on sworn circulation figures.

Conclusion

Our *Journal*, as is yours, is the outlet for the writings of the members of the association. The only papers by outsiders which we accept for publication are those read before Florida medical meetings. It therefore probably cannot be stressed too much that the state medical journal can be only as good as the members make it.

It is our purpose to try to simulate the authors of papers read before county medical societies, hospital staff meetings and district meetings to prepare these papers in suitable form for publication before read-

ing them. If so prepared, they will be better papers. One reason for rejection of papers is that not infrequently they have been prepared for reading without thought of publication and then submitted for publication without revision. We are reminded of a wise comment from the pen of an authority on medical writing, "A manuscript that is fit to read is sometimes fit to print, but a manuscript that is fit to print is always fit to read."

Permit me to congratulate you on your comprehensive official publication with its pleasing format. It renders invaluable service to your association—greater than many of you realize probably—and operates under able leadership. Nevertheless, it is only as good and as interesting as you yourselves make it. Every member can make some contribution to it, if only a news item. Certainly, all of you can peruse it carefully enough to offer, at the least, a word of commendation or a bit of constructive criticism aimed at increasing its usefulness. Adverse comment is much to be preferred to no comment at all. If you would warm your editor's heart, manifest interest in one way or another.

I would remind each and every member once again that the *Journal of the Medical Association of Georgia* is your *Journal*—yours, and yours, and yours—to make of it what you will.



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Report of

MAG INSURANCE BOARD

Meeting, Savannah, August 2, 1953

Attending a meeting of the Medical Association of Georgia Insurance Board held at the Hotel DeSoto, August 2, 1953 at 10:00 a. m. were the following members: John L. Elliott, Chairman, Savannah; J. Z. McDaniel, 2nd District, Albany; L. H. Wolff, 3rd District, Columbus; T. C. Jordan, 4th District, Thomaston; D. L. Wood, 7th District, Dalton; W. L. Pomeroy, 8th District, Waycross; G. T. Nicholson, 9th District, Cornelia; D. R. Thomas, 10th District, Augusta; and Mr. H. B. Coolidge, Secretary, Savannah.

Also in attendance were Mr. Richard Eales, New York, and Mr. Lambert Schulz, Chattanooga, of the Health Insurance Council. Mr. M. D. Krueger, Atlanta, represented the MAG headquarters office.

Minutes of the last meeting of the Insurance Board held June 14, 1953, Atlanta, were read and approved. A letter from A. M. Phillips, 6th District, Macon, expressing his regret that he was unable to attend was read.

An Executive Committee of the Board was nominated and the following members elected were: John L. Elliott, Savannah; O. B. Hanes, Atlanta; W. L.

Pomeroy, Waycross; D. L. Wood, Dalton; and J. Z. McDaniel, Albany.

Rules of procedure relative to future meetings were discussed and it was moved and seconded that future meetings be called at the discretion of the Board Chairman.

The Executive Committee was instructed to proceed with the proposed revision of the Georgia Plan fee schedule as soon as the various medical specialty sections forward their recommendations. It was recommended to the Executive Committee that anesthesia administered by a physician be added to the services offered by the Plan, if and when found feasible.

The Board expressed the opinion that it sincerely hoped that physicians, insurance carriers, Blue Shield, and others would cooperate in the Association's endeavor to bring medical care to all of the people of Georgia.

Other proposed changes in the Plan were discussed and it was the opinion of the Board that all revisions should be done at the same time and groundwork for these decisions should start immediately.

The meeting was adjourned at 4:00 p. m.

Report of

JMAG EDITORIAL BOARD

Meeting, Atlanta, August 12, 1953

Members present at a meeting of the Editorial Board of the *Journal of the Medical Association of Georgia* held at the Academy of Medicine, Atlanta, August 12 at 4:30 p. m. were

as follows: William F. Friedewald, Atlanta; William Harbin, MAG President, Rome; Ted F. Leigh, Atlanta; David Henry Poer, JMAG Editor, Atlanta; Lester Rumble, Atlanta; Peter L. Scardino, Savannah; Edgar Woody, Jr., JMAG Associate Editor,

Atlanta; Miss Thelma Franklin, *JMAG* Business Mgr., Atlanta; and Messrs. Milton D. Krueger, *JMAG* Mgr. Editor, Atlanta, and Sid Wrightsman, Jr., *MAG* Executive Secretary and *JMAG* Assistant Editor, Atlanta.

First on the agenda was the introduction of Edgar Woody, Jr., who will act in the capacity of Associate Editor of the *Journal*. The problem of stimulating editorials of timely interest was then discussed. A report on the financial aspects of advertising and subscription revenue and the rise in printing and production costs was presented.

Members of the Board then discussed the importance of condensing scientific articles for quicker reader comprehension. The six sections of the *Journal* were re-evaluated and plans for a Crawford W. Long Memorial Issue of the *Journal* were formulated. Publication priority and publication of Annual Session papers was considered in the light of present space commitments.

The following action was taken:

(1) Recommended that the Editorial Board be given the responsibility for securing editorial matter and be so informed.

(2) Recommended that because of the imbalance of *Journal* revenue with the rises in printing and production costs during the past two years that adver-

tising rates be increased 15 per cent and local advertising rates be standardized effective January 1, 1954. Also recommended that circulation be increased and the amount of local advertising be increased.

(3) Recommended that *Journal* revenue govern the amount of printing and production charges which can be controlled by the issue size monthly.

(4) Recommended that all scientific articles and special articles be condensed as the material permits, to insure approximately the same number of articles per issue.

(5) Approved the continuation of all six *Journal* sections as they now exist.

(6) Approved plans for a Crawford W. Long Memorial Issue of the *Journal* as soon as the specified material can be obtained.

(7) Approved the policy of Editorial Board consideration and review of all Annual Session papers to judge their merit for publication in the *Journal*.

(8) Approved Edgar Woody's plan for a compiled list of criteria to aid authors in the preparation of scientific material for publication. This will be distributed to prospective authors by members of the Editorial Board and the *Journal* office in an effort to facilitate medical writing for publication.

The meeting adjourned for dinner at 7:00 p. m.

Report of

MAG EXECUTIVE COUNCIL

Meeting, Atlanta August 26, 1953

The Executive Committee of Council of the Medical Association of Georgia met on Wednesday, August 26, 2:00 p. m., in the Academy of Medicine, Atlanta, with the following present: H. L. Cheves (Chairman), William P. Harbin, Jr., Peter B. Wright, George R. Dillinger, Mark S. Dougherty, Jr., Guy V. Rice, Jr., H. Walker Jernigan, James A. Green, R. Hugh Wood, Eustace A. Allen, Executive Director Mary Webb of the Georgia Society for Crippled Children and Mr. Sid Wrightsman, Jr.

The following action was taken:

1. Recommended referral to Council on October 18 of information on the Clarke County Handicapped Children Survey, to be sponsored by the Georgia Society for Crippled Children, with final action on which to be taken only after Council *in toto* be given opportunity to discuss existing facts on the situation.

2. Approved, contingent on his desire in the matter, resubmission to the American Medical Association of Dr. C. K. Sharp's historical and biographical credentials for his nomination as the General Prac-

itioner of the Year at the 1953 AMA Clinical Session in St. Louis.

3. Accepted resignation of Mr. Sid Wrightsman, Jr., Executive Secretary, to become effective on November 1, 1953, and extended heartfelt gratitude to him for "a job well-done."

4. Designated Veterans Affairs Committee Chairman Hartwell Joiner as official MAG representative to attend special AMA Conference on VA matters, Chicago, September 1, 1953, ordered his personal report on the Conference to Council at its October 18 meeting at Savannah, and recommended to Council his expense reimbursement.

5. Designated Public Relations Committee Chairman Chris McLoughlin as official MAG representative to attend the Second Annual AMA Public Relations Institute, Chicago, September 2-3, 1953.

6. Designated Guy V. Rice, Jr. as official MAG representative to attend the Fourth Annual Conference on Physicians and Schools, Highland Park, Ill., September 30-October 2, 1953.

The meeting adjourned at 5:50 p. m.

ANNOUNCEMENTS

SEPTEMBER 22: Muscogee County Medical Society will meet at 7:30 p. m. at the Standard Club, Columbus.

SEPTEMBER 24: Blue Ridge Medical Society is scheduled to meet at 7:00 p. m. at Harry's Cafe, Blue Ridge.

SEPTEMBER 28: Gordon County Medical Society will meet at 7:30 p. m. in Calhoun.

SEPTEMBER 28-29: Tennessee Valley Medical Assembly will convene in a two-day session at Read House, Chattanooga, Tenn. (See advertisement in front section)

SEPTEMBER 29: Polk County Medical Society will meet at 7:30 p. m. at the Wayside Inn, Cedar-town.

SEPTEMBER 29: Walker-Catoosa-Dade Medical Society will meet at the residence of G. C. Vassey in Chattanooga, Tenn., at 8:00 p. m.

OCTOBER 1: Coffee County Medical Society will meet at 1:00 p. m. at the Douglas Hospital, Douglas.

OCTOBER 1: Fulton County Medical Society will meet at 7:30 p. m. at the Academy of Medicine, Atlanta. Featured for the meeting is the E. C. Davis Memorial Lecture which will be given by R. W. TeLinde, of Baltimore, Md.

OCTOBER 1: Ware County Medical Society is scheduled to meet at 7:30 p. m. at the Ware Hotel, Waycross.

OCTOBER 2: Jenkins County Medical Society will hold their meeting at 7:30 at the Burke County Hospital, Waynesboro.

OCTOBER 2: Chattooga County Medical Society meets at 7:30 p. m. at the Chattooga County Hospital, Summerville.

OCTOBER 2: Burke County Medical Society will meet at 7:30 p. m. at Waynesboro.

OCTOBER 5-9: The 39th Annual Clinical Congress of the American College of Surgeons will be held in Chicago with headquarters at the Conrad Hilton Hotel.

OCTOBER 5: Cobb County Medical Society will hold their monthly meeting at 7:00 p. m. at the Kennestone Hospital, Marietta.

OCTOBER 5: Telfair County Medical Society will meet at 8:00 p. m. at the Telfair County Hospital, McRae.

OCTOBER 6: Upson County Medical Society will meet at 7:30 p. m. at the Upson County Hospital, Thomaston.

OCTOBER 6: Tift County Medical Society meets at 7:30 p. m. at the Tift County Hospital, Tifton.

OCTOBER 6: Bibb County Medical Society will meet either at the Pinebrook Inn or the State Health Department, Macon.

OCTOBER 6: Hall County Medical Society will meet at 7:30 p.m. at the Avion Restaurant, Gainesville.

OCTOBER 8: Jefferson County Medical Society will hold their monthly meeting at the Jefferson Hotel, Louisville, at 8:00 p.m.

OCTOBER 9: Randolph-Terrell Medical Society will meet at 8:00 p.m. at the Patterson Hospital, Cuthbert.

OCTOBER 12: Walton County Medical Society meets at 7:30 p.b. at the VFW Home, Monroe.

OCTOBER 12: DeKalb County Medical Society will meet at 7:30 p.m. in the DeKalb County Health Building, Decatur.

OCTOBER 13: Altamaha County Medical Society will meet in the General Hospital, Baxley, at 8:00 p.m.

OCTOBER 13: Eighth District Medical Society will meet in Waycross.

OCTOBER 14: Seventh District Medical Society will meet at 2:00 p.m. at the Chattooga County Memorial Home, Summerville.

OCTOBER 15: Habersham County Medical Society will meet in the Commercial Hotel, Cornelia, at 7:30 p.m.

OCTOBER 15: Richmond County Medical Society will meet at 7:30 p.m. at the Old Medical College, Augusta.

OCTOBER 15: McDuffie County Medical Society will meet at 8:00 p.m. in the McDuffie County Hospital, Thomson.

OCTOBER 16-17: The Annual Meeting of the Georgia Academy of General Practitioners will be held at the Hotel DeSoto, Savannah. This meeting will mark the GAGP first two-day annual meeting.. Commercial and Scientific exhibits are set up for this meeting.

OCTOBER 17-20: The Sixth Annual Meeting of the American Association of Blood Banks will convene at the LaSalle Hotel, Chicago. For further information write: Secretary, AABB, 3500 Gaston Ave., Dallas 4, Tex.

OCTOBER 18: The Council of the Medical Association of Georgia will meet in Savannah at the residence of Howard Morrison.

OCTOBER 26-30: The 47th Annual Meeting of the Southern Medical Association will be held at the Municipal Auditorium, Atlanta. Registration, Scientific and Technical Exhibits, and Section Meetings will all be held at the recently air-conditioned Atlanta Municipal Auditorium.

SOCIETIES

Ninth District Medical Society met at the Hall County Hospital, Gainesville on September 9 at 2:00 p.m. After a tour of the hospital and a business session the scientific program was presented. Herbert Valentine, Jr. and P. F. Brown, Jr. delivered a paper on "Arrhenoblastoma." Rafe Banks, Jr. spoke on the "Management of Injuries of Genito-Urinary Tract," and Martin Smith, C. W. Whitworth, and E. L. Ward gave a paper on "Acute Otitic Hydrocephalus."

The social hour was held at the residence of Dr. and Mrs. E. L. Ward. And the Society dinner was held at the Dixie Hunt Hotel.

The Woman's Auxiliary met in conjunction with the Society.

Tenth District Medical Society held its annual summer meeting at Thomson August 20 with the following scientific program: "Recent Advances in Pre- and Post Delivery Care" and "Remarks on Complicated Delivery" by Bothwell Traylor and Tom A. Dover, respectively, both of Athens; and "Comments on Gynecological Surgery" and "Anesthesia for Obstetrical and Gynecological Operations" by William S. Boyd and Aubrey J. Waters, respectively, both of Augusta.

The following Tenth District Society officers for 1953-54 were elected: Bothwell Traylor, Athens, President; Edgar J. Maxwell, Jr., Thomson, Vice-

OCTOBER 30: Georgia State Obstetrical and Gynecologic Society will meet in Athens, Ga., at 10:00 a.m. Scheduled to address the meeting are George W. Anderson, Department of Obstetrics, Johns Hopkins University; and William L. Caton, Chairman, Department of Obstetrics, Emory University School of Medicine.

President; and Donald W. Schmidt, Lincolnton, Secretary-Treasurer.

Calhoun-Early-Miller Medical Society members and their wives were entertained July 22 in Colquitt at the Methodist Church Annex where the wives of the Colquitt physicians served a barbecue dinner. At the scientific session S. P. Holland, of Blakely, gave a report on "Eclampsia" and Warren Baxley, of Blakely, discussed "Orthopedic Problems in General Practice."

Cherokee-Pickens Medical Society and Auxiliary enjoyed a picnic and an afternoon swim at the lakeside cottage of Dr. and Mrs. E. A. Roper at Tate Mountain Estates.

Habersham County Medical Society held their regular monthly meeting August 20 at the Commercial Hotel, Cornelia. W. H. Good, of Toccoa, presented a paper on "Section for Monsters."

Washington County Medical Society recently endorsed a move to form a Washington County Walking Blood Bank and commended the participating organizations. The endorsement was signed by F. T. McElreath, President; O. D. Lennard; M. W. Hurt; O. L. Rogers; N. Overby; E. G. Newsome; N. J. Newsom; William Rawlings; B. L. Helton; William S. Helton; R. L. Taylor; and J. E. Lever.

Ware County Medical Society met August 6 at the Ware Hotel, Waycross. W. A. Risteen, Professor of Neuro-Surgery, University Hospital, Augusta, presented a paper on "Trauma of the Nervous System."

PERSONALS

William R. Anderson, formerly of Columbus, assumed medical practice in association with Schley Gatewood and Bon Durham, with offices on South Lee Street, Americus.

Jerome Berman, of Atlanta, has opened his offices for the practice of pediatrics at 248 Pharr Road, Atlanta.

Frank K. Boland, of Atlanta, recently gave material assistance in an advisory capacity to the Frank Wisbar production of the life of Crawford W. Long which was slated for TV audience September 8 on Fireside Theater. Another honor bestowed on Boland was the eloquent tribute to his life and achievements given by Governor Herman Talmadge at the

dedication of the Frank K. Boland Psychiatric Building at Milledgeville State Hospital.

Twenty Augusta physicians headed by *Steve Brown*, of Augusta, have laid plans to erect five-story office building on Harper Street convenient to the rapidly growing medical center.

W. W. Buckhaults, formerly of Atlanta, announces the opening of an office for the practice of ophthalmology at 103 East Jones Street, Savannah.

Eleanor E. J. Bundy, of Decatur, announces the opening of offices for the general practice of medicine at 603 Church Street, Decatur.

William W. Bryan, of Atlanta, announces the association of *J. Frank Walker*, of Atlanta, in the practice of radiology at Suite 5, Howell House, 710 Peachtree Street, NE, Atlanta.

C. Walter Coolidge, of Atlanta, has associated with

C. Stedman Glisson, Jr., and *Arthur A. Smith* in the practice of obstetrics and gynecology at 1102 West Peachtree, NE, Atlanta.

Guy C. Davis, of Atlanta announces the opening of his office for the practice of general surgery at Suite 1, Howell House, 710 Peachtree Street, Atlanta.

W. A. Dodd, of Wrightsville, recently returned from a two-weeks tour of duty at Fort McClellan, Ala.

Laurence B. Dunn, of Savannah, was recently named county physician.

O. O. Fanning, of Atlanta, is a patient at Columbia Hospital, Columbia, S. C. where he is convalescing from an illness that occurred while he was visiting relatives in that area. His family expects his return to Atlanta within a month.

George Green, who was formerly in practice with *David E. Taner*, has moved to Sparta where he has opened offices.

T. C. Jefford, of Sylvester, was recently appointed a director of the Worth County Hospital.

William G. Keiter, formerly of Augusta, has opened his office for the general practice of medicine in Greensboro.

Robert M. Martin, Jr., a native of Madison, Ala., is now associated with *Joseph C. Brown* in Conyers.

John McPherson, *John Stegeman*, and *John Elder*, all of Athens, addressed a recent meeting of the Athens Rotary Club.

A. O. Meredith, Jr., recently opened his office in the Homer Herndon Building, Hartwell.

D. Frank Mullins, Jr., of Augusta, has accepted an appointment by the University of Georgia Board of Regents as Acting Professor of Pathology at the Medical College of Georgia.

Bruce C. Newsom, of Augusta, is now surgical chief resident at the University Hospital, Medical College of Georgia, Augusta.

T. L. Parker, and Mrs. Parker of Douglas, named their baby daughter born August 12, 1953, "Lora Ross."

Hayward S. Phillips, of Augusta, has been scheduled to present a paper titled "Physiologic Changes Noted with the Use of Succinylcholine Chloride as a Muscle Relaxant During Intubation" at the annual meeting of the International Anesthesia Research Society, Quebec, Canada, on October 26.

Thomas Reeve, of Carrollton, recently left Carroll-

ton for a year of further surgical training at Piedmont Hospital, Atlanta.

The Buckhead Clinic, Atlanta, announces the association of *Ralph L. Robinson* with a practice limited to pediatrics.

Cyrus K. Sharp, of Arlington, was recently honored with a cover picture and a two page spread in the *Atlanta Journal and Constitution Magazine* section. The article related his contributions to medicine, then and now, and described many incidents from Sharp's 55 years of medicine in that area.

W. H. Tanner and Mrs. Tanner, of Roscoe, had the pleasure of attending a picnic supper recently given in their honor by friends and neighbors. After 50 years of service to the community, tokens of esteem were presented to the Tanners at this occasion.

George S. Tootle, of Atlanta, announces the opening of his offices for the practice of general surgery at 302 Thomas K. Glenn Memorial Building, 69 Butler Street, SE, and Suite 305, Doctors Building, 478 Peachtree Street, NE, Atlanta.

Richard Torpin, professor of Obstetrics and Gynecology at the Medical College of Georgia recently spoke before the Augusta Rotary Club.

Perry Volpitto, of Augusta, was a guest speaker at the annual meeting of the Ohio Society of Anesthesiologists in Cleveland, Ohio, September 12, and presented the following papers: "The Management of Anesthesia in Children" and "The Problem of Anesthesia in Operative Obstetrics."

J. Calvin Weaver, of Atlanta, has been commended by the DeKalb County History Club for an "invaluable contribution" to the County's existing historical records. The Club's action followed the completion and private publication of his history of DeKalb County medicine from 1822-1922.

Dan H. Willoughby, formerly of Nashville, Tenn., is now associated with *Ellison R. Cook*, of Savannah.

L. E. Wilson, of Bowdon, recently was presented a 50-year service pin by the Medical Association of Georgia, in recognition of his outstanding service to the community for the past 50 years.

Robert U. Young, formerly of Atlanta, has opened offices in Lawrenceville.

Representing Georgia medicine at the 18th Annual Meeting of the Piedmont Post-Graduate Clinical Assembly held September 16-17 at the Clemson House, Clemson, S. C. are the following physicians who will present papers at this time: *Carter Smith*, Atlanta; *John R. McCain*, Atlanta; *R. Bruce Logue*, Atlanta; *Osler A. Abbott*, Atlanta.

ALLEN: *Myron B. Allen*, 58, of Houshton, died July 20 at Georgia Baptist Hospital, Atlanta, after an extended illness. One of north Georgia's better

DEATHS

known pathologists and general practitioners, he was a graduate of Emory University School of Medicine, 1918. Following his graduation, he began his medical practice in Houshton in association with his father. In 1928 he and his father opened the Allen Hospital where he practiced until his death.

BRYANS: *Charles Iverson Bryans*, 70, died July 18 after a lengthy illness at his residence. A graduate of the Medical College of Georgia, 1904, he later served on the Medical College of Georgia faculty as Associateship to the Chair of Ophthalmology and Otolaryngology in 1924 and was later appointed Clinical Professor in this department. In 1933 he was appointed to head this department at the Medical College. A resolution was passed by the Medical College faculty memorializing and lauding Charles I. Bryans immediately after his death.

DORMINEY: *James Norwood Dorminey*, 83, of Cordele, died August 2 in the Americus and Sumter County Hospital after having been in declining health for some time. A graduate of the Medical College of Georgia, 1896, he practiced for 50 years in Cordele. He had retired from active practice several years ago.

HIGHSMITH: *Emmett deWitt Highsmith*, 83, of Atlanta, died August 11 in a private Atlanta hospital after a long illness. A graduate of the former

Atlanta College of Physicians and Surgeons, 1906, he later served on the faculty of Emory University School of Medicine. Considered a pioneer in plastic surgery, he retired in 1938 after 32 years of service in his profession.

MILES: *William Clinton Miles*, 71, of Griffin, died July 12. Having practiced in Griffin since 1911, he retired recently due to poor health. A graduate of the former Atlanta College of Physicians and Surgeons in 1908, he was a native of Pike County and a past president of Spalding County Medical Society.

SMITH: *James M. Smith*, 77, of Cochran, died July 31. Born in Twiggs County near Macon, he was a graduate of the former Atlanta School of Medicine, 1911. He practiced in Cochran since 1921 after having practiced in Oglethorpe County for 10 years. He was recently awarded Life Membership in the Medical Association of Georgia.

STRICKLER: *Cyrus W. Strickler*, 79, of Atlanta, died July 23. He was a graduate of the Emory University School of Medicine, 1897, and started the first clinical laboratory in Atlanta at Grady Hospital while he was an intern there before the turn of the century. He had served as Professor of Medicine at Grady Hospital and continued his active practice until April of this year.

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**The Journal of the
American Chemical Society**

VOL. 50

FEBRUARY, 1928

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**THE ACTIVE PRINCIPLES OF THE POSTERIOR LOBE OF THE
PITUITARY GLAND. I. THE DEMONSTRATION OF THE
PRESENCE OF TWO ACTIVE PRINCIPLES. II. THE
SEPARATION OF THE TWO PRINCIPLES AND THEIR
CONCENTRATION IN THE FORM OF POTENT SOLID
PREPARATIONS**

By OLIVER KAMM, T. B. ALDRICH, I. W. GROTE, L. W. ROWE AND E. P. BUGBEE

RECEIVED DECEMBER 31, 1927

PUBLISHED FEBRUARY 4, 1928

Introduction

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The JOURNAL
of the
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OCTOBER, 1953
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Photo by Ted F. Leigh, M.D.

The cover picture is one of some 50 photographs of a series called "Faces of the Hospital." As a part of the program of the MAG Public Relations Committee, this exhibit will be sent to public libraries and high schools throughout the state. Through this graphic visualization of hospital people performing their various tasks, an effective step toward hospital personnel recruitment is being met.

Hospitals over the state are in great need of trained personnel (nurses, technicians, aides, attendants, etc.) and the field offers unusual opportunities to the youth of Georgia. If the exhibit inspires more interest in this type of work, it will render a service of great value to the citizenry of Georgia.

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STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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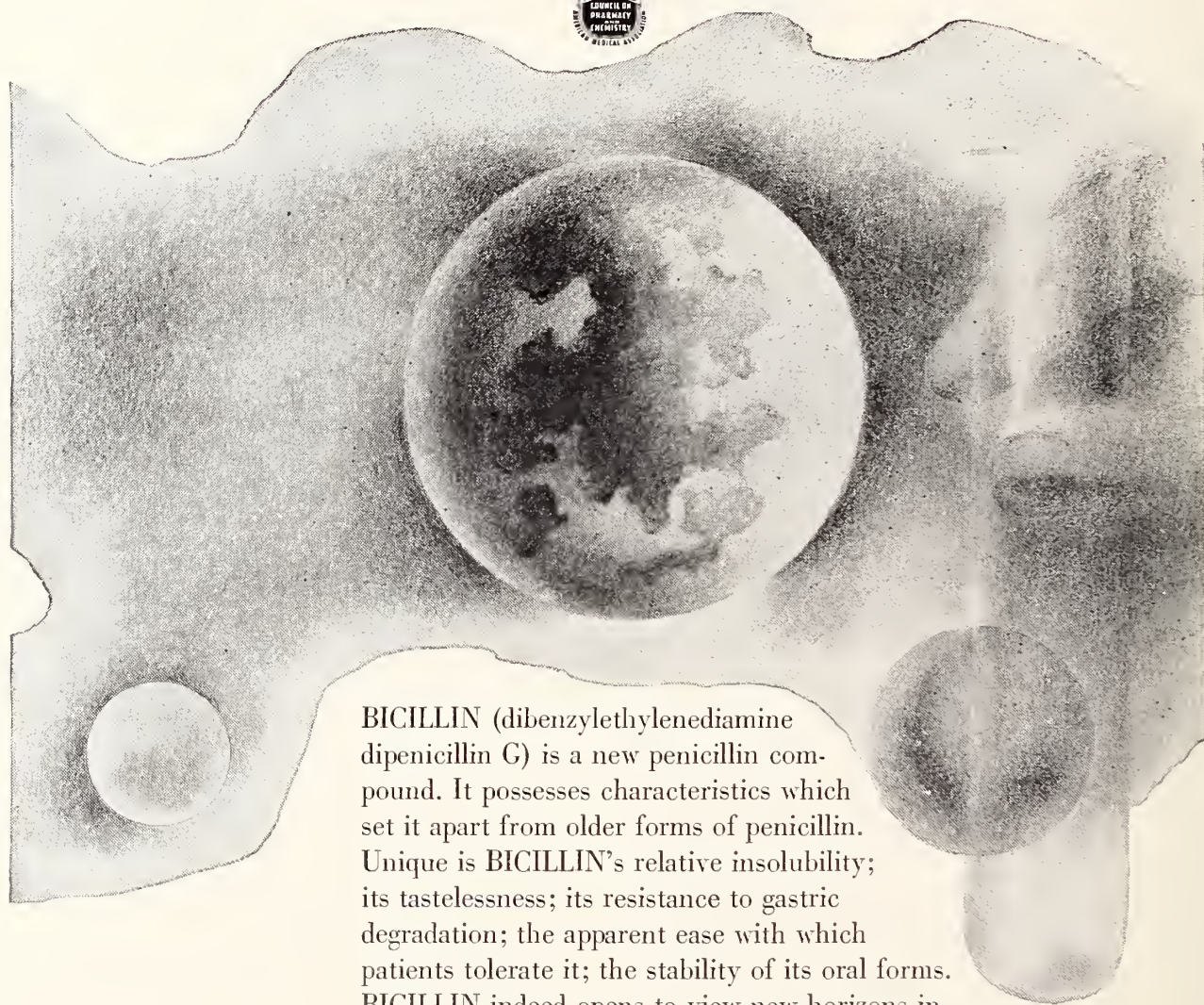
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BOOKS RECEIVED

RESPIRATORY DISEASES AND ALLERGY: By Josef S. Smul, M.D., Author of Digestive Diseases and Food Allergy, Fellow National Gastro-Ent. Assoc.; Member N.Y. Academy of Sciences. Formerly: Vice President Manhattan Roentgen Ray Soc.; Assoc. Gastro-Ent. Beth David Hospital; Clin. Asst. Phys. Beth Israel Hospital. 72-pages. Published by Medical Library Company, New York. Price \$2.75.

MAY'S MANUAL OF DISEASES OF THE EYE: For Students and General Practitioners, Twenty-First Edition Revised and Edited by Charles A. Perera, M.D.,

Associate Clinical Professor, College of Physicians Surgeons, Columbia University, New York; Attending Ophthalmologist, Presbyterian Hospital, New York. 485 pages with 378 illustrations, including 32 plates, with 93 colored figures. Published by Williams & Wilkins Company, Baltimore, Maryland. Price \$6.00.

THE NURSING MOTHER: A Guide to Successful Breast Feeding, by Dr. Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P., Pediatric Introduction by Clifford G. Grulee, M.D., Founder of the American Academy of Pediatrics, Chicago, Ill.; Obstetric Introduction by Nicholson J. Eastman, M.D., Obstetrician-in-Chief, Johns Hopkins Hospital, Baltimore, Md. Published by Prentice-Hall, Inc., 70 Fifth Avenue, New York 11, N. Y. 199 pages. Price \$2.95.

REVIEWS

HISTORY OF PUBLIC HEALTH IN GEORGIA by T. F. Abercrombie, Atlanta. Longino & Porter. 288 pages.

In contemplating "The Medical History of Georgia," it has occurred to me that when and if it is ever written one chapter should be devoted to books written by Georgia doctors, with a thumbnail sketch of each author.

So, it gives me much pleasure to be able to add Dr. Abercrombie's book to the list already compiled.

History of Public Health in Georgia is a fitting climax to thirty years of work he loved and is a most valuable document to round out Georgia Medical History. No other of the earlier historians,—McCall, Stevens, or Jones or Smith, devoted any space to the medical profession.

In his preface, Dr. Abercrombie tells us interesting facts about public health before Georgia was founded; his handling of conditions in early Georgia has been a refresher course for me on Georgia as a Colony and as a Province, and further along his narrative has allowed me to live over "days that are gone, never to return."

I knew H. F. Harris, the first State Health Director, and knew "Old John," his negro "Man Friday" who could mimic him to perfection and who could relate many humorous incidents about him.

It is amazing to know what three capable, conscientious men in a span of 50 years have accomplished, beginning with "one employee, a borrowed

microscope and a basement room and building to a complex organization, housed in numerous buildings, and employing approximately 500 *trained* employees."

His health "firsts" are interesting, but Georgia has many more medical and surgical "firsts" that do not come under public health.

There is a remarkable contrast between the still-borns one hundred years ago and now, thanks to Public Health, Salvarsan and Penicillin.

His book has made a permanent record of Dr. Claud A. Smith's valuable contribution to the work on hookworm disease and Dr. H. F. Harris' report of the first authenticated case of pellagra in the United States.

It is almost inconceivable how much work has been done toward eradicating communicable diseases, hookworm, pellagra, typhoid, dysentery, malaria, venereal diseases; early maternal and child welfare, midwife supervision and instruction, public health engineering, early dental health and a host of others.

In summary, he declares, "Degenerative diseases resulting from the lengthening of life span and consequent ageing of the population offer a challenge to public health in the future. These diseases are the joint responsibility of both the medical and public health professions. They offer a relatively untouched field to both groups."

To sum up, the illustrations are excellent, his collaborators were painstaking, careful and accurate, and he, with their help, has turned out a most valuable addition to "Georgia Medical History."

The book should be read by every doctor in Georgia with an eye to seeing what public health in Georgia was, is, and eventually will be.

"MECHANISMS OF UROLOGIC DISEASE" by David M. Davis, M.D. Published by W. B. Saunders Co. 1953.

This is a comprehensive introduction to urology for the beginner, a handy summary for the practitioner, and a review for the urologist. It takes its origin from a series of lectures prepared by the author for Junior medical students and, as a result, is oversimplified. It deals in general principles of urologic disease and therapy rather than details, but gives complete reference to source material of details for the interested reader.

The approach to disease of the urinary tract is different from most. The author deals with the urinary

tract as a unit rather than using the usual anatomical approach. He has a chapter devoted to each of the following: obstruction, infection, stone formation, neoplasms, congenital abnormalities, trauma, foreign bodies and neurogenic changes. The effect of each of these processes on the entire urinary tract is pointed out. He further adds a chapter on infertility as encountered in the male and another chapter on lesions of the scrotal contents, and also, lesions of the external genitalia. He then devotes a chapter to the use of catheters and in the end gives an outline for the proper taking of history and physical examination on the urologic patient.

This is a nicely written monograph and should be highly recommended for the medical student and is desirable for the practitioner. It would be of questionable value to the practicing urologist.



georgia medical specialty societies

Georgia Heart Association

Joseph Masee, M.D., President, 21 Eighth Street, N.E., Atlanta.

Lamont Henry, M.D., Secretary, 30 Prescott Street, N.E., Atlanta.

Georgia Chapter

American College of Chest Physicians

John Elliott, M.D., President, 212 East Hunting-ton Street, Savannah.

Clarence Mills, M.D., Secretary, 384 Peachtree Street, N.E., Atlanta.

Georgia Urological Society

James L. Pittman, M.D., President, 478 Peach-tree Street, N.E., Atlanta.

J. Z. McDaniel, M.D., Secretary, C & S Bank Building, Albany.

Georgia Pediatrics Society

Harold W. Muecke, M.D., President, Waycross.

J. Harry Lange, M.D., Secretary, 490 Peachtree Street, N.E., Atlanta.

Georgia Orthopedic Society

F. B. Brown, M.D., President, 22 West Gaston Street, Savannah.

C. G. Henry, M.D., Secretary, 842 Green Street, Augusta.

Georgia State Obstetrical and Gynecological Society

Hugh Bickerstaff, M.D., President, Medical Arts Building, Columbus.

Eugene Griffin, M.D., Secretary, 26 Linden Avenue N.E., Atlanta.

Georgia Trudeau Society

Rufus Payne, M.D., President, Medical College of Georgia, Augusta.

Sam E. Patton, M.D., Secretary, 797 Poplar Street, Macon.

Georgia Industrial Surgeons Association

Joseph C. Read, M.D., President, Medical Arts Building, Atlanta.

A. M. Collingsworth, M.D., Secretary, 663 West Peachtree Street, N.E., Atlanta.

Georgia Chapter American College of Surgeons

Thomas Harrold, M.D., President, 700 Spring Street, Macon.

James H. Semans, M.D., Secretary, 34 Seventh Street, N.E., Atlanta.

Georgia Radiological Society

Stephen W. Brown, M.D., President Southern Finance Building, Augusta.

Robert M. Tankesley, M.D., Secretary, 218 Doctors Building, Atlanta.

Georgia Association of Pathologists

Lee Howard, M.D., President, DeRenne Apartments, Savannah.

Darrell Ayer, M.D., Secretary, 35 Linden Avenue, N.E., Atlanta.

Georgia Society of Ophthalmology and Otolaryngology

W. Eugene Matthews, M.D., President, Southern Finance Building, Augusta.

Alton V. Hallum, M.D., Secretary, Doctors Building, Atlanta.

Georgia Academy of General Practice

Peter Hydrick, M.D., President, 106 Auditorium Drive, College Park.

Maurice F. Arnold, M.D., Secretary, Hawkinsville.

Georgia Society of Anesthesiologists

C. M. Westfield, M.D., President, 101 Garrard Avenue, Savannah.

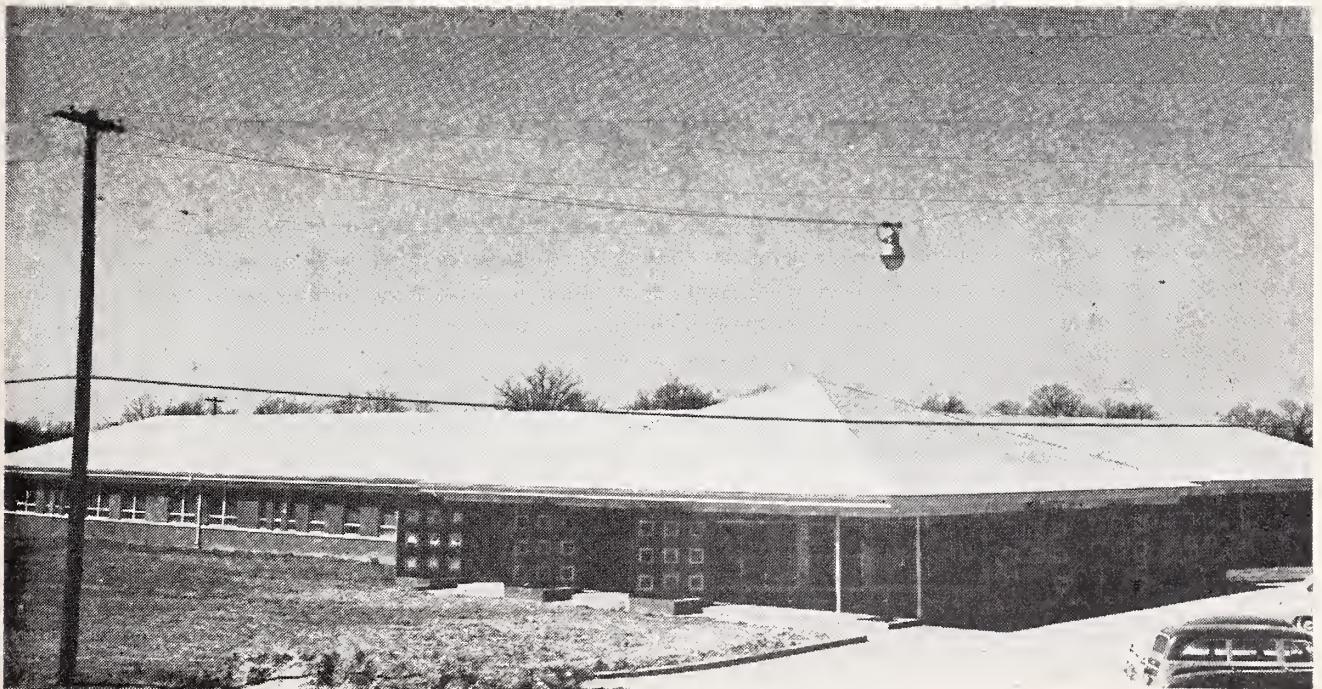
A. J. Waters, M.D., Secretary, University Hospital, Augusta.



Douglas-Coffee County Hospital
Douglas, Georgia

The 60-bed Douglas-Coffee County Hospital has an unusually attractive setting in a background of pine trees. Patients will be received for the first

time here during October. It replaces the old 31-bed Douglas Hospital which is being closed and will be utilized for other purposes.



Rockmart-Aragon Hospital
Rockmart, Georgia

The Rockmart-Aragon Hospital, Rockmart, Georgia, shown here, has been opened for the reception of patients since January of this year. It has 25 beds,

and fills a great need in the community because it is the first hospital in the immediate area.



From where I sit by Joe Marsh

An Honest Night's Sleep

Slim Johnson, just back from a business trip, tells about a hotel he stayed at one night.

"I arrived in town late and went right to the hotel. There was no clerk at the desk, but there was a sign that said: 'Have gone to bed. Rooms \$3. Please take a key. Pay when you leave. Sleep Well.'"

"Upstairs, the room was real clean, the bed comfortable and I slept like a log. Came down in the morning—still no clerk. So I left three dollars at the desk and went on. Can you imagine folks that trustful?"

From where I sit, running a hotel on the honor system shows a real trust in people. And people always appreciate being trusted. Letting the other fellow follow his profession without interference is one way of trusting your fellow citizens. So is your regard of my liking an occasional glass of beer. You may prefer buttermilk, but let's hope neither of us "register" a complaint against the other.

Joe Marsh

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HYPERTENSION--

An Editorial Review

With the etiology of arterial hypertension still in doubt, many physicians have come to regard the disorder as involving an interplay of multiple factors. Kidneys, vascular tree, sympathetic nervous system, endocrine glands, electrolytes and emotional influences all have been implicated, yet no satisfactory pathogenesis can yet be assigned to more than ninety per cent of cases. These we must still call essential hypertension.

Accepting for the present, then, this etiologic ignorance which prevails in most cases, it is helpful to consider the wide variety of stimuli demonstrated to participate in hypertension as factors which may modify the clinical picture in a given patient. Thus hyperactivity of the sympathetic nervous system will appear to be more important in one patient whereas renal and perhaps other humoral factors may predominate in another.

It is well to remember that the blood pressure level itself is merely a clinical manifestation of the underlying vascular disease process. The primary *physiologic concomitant* of hypertension is an increase in the tone of the arterioles throughout the body. This constriction, by producing impedance to blood flow, causes more forcible heart action and if sustained may lead to hypertrophy of the left ventricle. In addition to the heart, the main target organs of hypertension are the kidneys and brain, since persistent elevations of blood pressure may ultimately be associated with degenerative changes in the vessels of these viscera.

Benign and *malignant*, as currently applied in cases of hypertension, indicate both rapidity of progression and in part the relative severity of the arteriolar spasm. The outstanding clinical features which mark the transition of benign into the malignant phase of hypertension are the appearance in the ocular fundi of hemorrhage, exudates and/or papilledema. Accompanying this acceleration of the disease is impairment of kidney function, progressing over a period of weeks or months to renal failure and death in uremia. Once the malignant phase of hypertension has been established in the kidney the ultimate fatal prognosis is clear cut.

The natural history of benign hypertension is much less well understood than is that of its rapidly progressing counterpart. Many individuals with moderate elevation of blood pressure may live long and healthy lives uncomplicated by the appearance of malignant acceleration, heart failure or cerebrovascular accident.

Differential Diagnosis

Differential diagnosis actually resolves itself into

a decision as to whether a given case of hypertension must be placed in the category of "essential." Certain specific disorders which may be associated with blood pressure elevation must be ruled out. These include acute and chronic glomerulonephritis, polycystic kidney, chronic pyelonephritis, unilateral kidney disease, toxemia of pregnancy, coarctation of the aorta and pheochromocytoma. The hypertension associated with any of these conditions may present either a benign or malignant clinical picture. Chronic nephritis nearing a terminal phase may be impossible to differentiate clinically from malignant essential hypertension. Intravenous pyelography is necessary to single out the rare instance of unilateral kidney disease. Measurement of the blood pressure in both arms and legs, palpation of femoral pulses and a search for superficial collateral vessels may suggest the presence of coarctation of the aorta. Notching of the ribs must be sought in the chest x-ray. Aortography, the taking of serial x-rays following instillation of opaque medium into the great vessels, may not only aid in diagnosis but will likewise help in deciding about amenability to surgical intervention. The hypertension produced by epinephrine-secreting tumors of the adrenals is transiently abolished by regitine, benzodioxane and dibenamine. Extensive work with the former two drugs has established their value as screening agents for both diagnosis and exclusion of pheochromocytoma. Roentgenologic study following perirenal air insufflation may be an aid in localization of the tumor and in rational planning for surgery.

The mild to moderate hypertension so frequently encountered in association with anxiety and highly charged emotional situations is deserving of special mention. Such blood pressure elevation, usually rapidly transient in nature, is often the result of nervous tension surrounding a physical examination, insurance appraisal or the like. Careful evaluation under relaxed circumstances usually results in reversion to normotensive levels. There is no conclusive evidence that such fluctuation represents a pre-hypertensive state or that nervous tension plays a primary role in the pathogenesis of essential hypertension.

Essential Hypertension

Since approximately 90 per cent of the hypertensive patients fall into this category, these are the patients with whose care the physician is mainly concerned. Differential diagnostic considerations have already

been discussed. Recognition of the degree of progression or absence of progression is a point of primary importance. It can and must be established by careful clinical and laboratory appraisal. Ophthalmoscopic examination, urinalyses, renal function tests (concentrating ability, excretion of PSP dye, urea clearance), heart size by teleoroentgenogram, electrocardiogram, all may yield valuable information which will enable the doctor to a proper assessment of his patient's physical status. That accomplished, he will find himself on more secure grounds in attempting to outline a program of management for the individual patient. As with most disorders he will usually reserve the more drastic therapeutic maneuvers for the most seriously ill. The physician's greatest problem is likely to be in the evaluation and management of the symptoms voiced by his patient. It is usually impossible to find a pathophysiologic source for the hypertensive symptoms of headache, nervousness, dizziness, insomnia, dyspnea and fatigability. Recent investigations have done much to clarify the reasons for this. There is now fairly general agreement that the level of the blood pressure rarely bears any organic relation to the complaints of the hypertensive patient. Headaches are usually of the tension variety but may simulate migraine. Non-specific measures including simple reassurance may bring symptomatic relief without alteration of the blood pressure level. Other subjective symptoms may yield similarly.

Through the careful physical appraisal the physician will go far toward establishing a strong doctor-patient relationship. He will be in a more secure position to offer deep-going reassurance when clinical circumstances warrant, to minimize the importance of the blood pressure level, and to relieve the many misapprehensions about high blood pressure that accrue to all hypertensive patients.

Treatment

Since the etiology of so large a proportion of cases of hypertension is in doubt, there can be little wonder that suggested forms of treatment are of such wide and varied types. The very rare case of unilateral kidney disease, producing a Goldblatt type lesion may be cured by nephrectomy. Similarly removal of an epinephrine-producing tumor may abolish the hypertensive state. Surgery for correction of coarctation of the aorta has met with only variable degrees of success in terms of blood pressure reduction. Specific therapeutic measures are available only in the cases mentioned, those being ones where a definite etiology is known.

Thus the first move toward the planning of rational therapy in a given case of essential hypertension must include satisfactory establishment of the diagnosis to rule out the rare types mentioned above. Similarly the diagnostic evaluation must provide the information regarding renal and cardiac function and funduscopic changes to help the physician to categorize the stage of illness as *benign* or *malignant*. This knowledge will enable him to better define his therapeutic aims in a given case.

Thus if cardiac, renal or cerebral complications of hypertension are revealed by the physical appraisal

the doctor will have clarified the limits of his therapeutic goals. Absence of these evidences of progression will enable him to provide his patient with more wholehearted reassurance.

Management of the symptoms of headache, et al. is usually the physician's main problem in handling the benign hypertensive. These patients often suffer from a subclinical type of chronic depression which may escape notice. Kindly, sympathetic listening and reassurance, utilization of the doctor-patient relationship in its fullest sense will go far toward bringing these troublesome symptoms under control. Phenobarbital in doses of grs. $\frac{1}{4}$ to $\frac{1}{2}$ three or four times a day is a valuable pharmacologic adjunct in many instances. Disappearance of symptomatology will most often occur without demonstrable effect on the blood pressure level. The occasional patient with severe emotional problems may require intensive psychotherapy by a psychiatric consultant.

The large number of pharmacologic agents available for presumed depressant effects on blood pressure level bespeaks their uncertainty and lack of efficacy. As yet too there is no good evidence that lowering of the blood pressure in hypertensive patients produces any retardation in the arteriolar disease. Therapeutic claims for the thiocyanates, nitrites, veratrum and quarternary and longer chain ammonium bases have not justified earlier optimism. The thiocyanates, it is agreed, are capable of inducing significant blood pressure reduction in about one-third of hypertensive patients, but severe toxic reactions and even fatalities have attended their use. The veratrum preparations likewise have an exceedingly narrow margin of safety and are often ineffective in tolerated dosage. Experiences with the dehydrogenated ergot alkaloids have proven disappointing. Hydrazinophthalazine and hexamethonium singly and in combination appear to exert significant depressor effects in some patients, especially when administered parenterally. However, variability of absorption and certain hazardous side reactions may attend their oral administration and as yet evidence is lacking that their use produces any long term modification in the course of the underlying vascular disease. The preparations of *Rauwolfia Serpentina* have not yet been thoroughly investigated but most of the effects ascribed to them appear to be due to a depressant effect on the central nervous system.

The measures just outlined constitute the main therapeutic possibilities for the patient with benign hypertension and in general deserve to be considered as *conservative measures*. When physical evidences of acceleration of the vascular process are noted, most observers feel that more drastic attempts at therapy are indicated.

Attempts to treat malignant hypertension with renal extracts and tyrosinase on the basis that human hypertension and experimental hypertension are similar have met with no success. The prolonged fever treatment with bacterial pyrogens as described by Corcoran and Page has not produced uniform results although some remissions have been observed. Surgical splanchnicectomy and sympathectomies of varying extent have also failed in general to alter the course of accelerated hypertension. There is some

evidence that extensive resection of the sympathetic ganglia may offer better therapeutic prospects than have procedures of more limited extent. The vagaries and lack of predictability of hypertension preclude any honest evaluation as to whether the medical prognosis of a benign hypertensive can be improved by such procedures.

Dietary maneuvers have come in for much attention in recent years. Diets delivering as little as 0.2 Gm. sodium per day can now be accomplished with the use of dialyzed milk preparations. The rice diet of Kempner, "dehydration" regime of Gold and all similar "desalting" maneuvers appear to exert some depressor effect in certain hypertensive patients. Some degree of pressure reduction by withdrawal of the sodium ion can be achieved in about one-fourth of hypertensives according to Page and Corcoran. These blood pressure changes may often be statistically but not clinically significant. The unpalatability of the diets together with the difficulties of maintaining a real "desalted" state except in patients hospitalized for long periods, precludes the extensive use of such

regimes. Their therapeutic usefulness appears to be quite limited in most phases of hypertensive disease.

Current investigation of possible therapeutic effects of subtotal and total adrenalectomy are being watched with much interest. Early results, however, do not appear encouraging. Similarly the use of drugs and drug combinations currently available show little promise of being able to produce lasting reversion of the accelerated phase of hypertension.

Although no single, ideal, widely-effective remedy has yet appeared on the hypertensive horizon the experiences with the current armamentarium are of great advantage. They are bringing to the individual hypertensive patient an understanding never before achieved. The complex natural history of the disease is slowly being clarified, and certainly a more optimistic prognosis can be properly assigned to the patient with benign hypertension. The understanding and reassurance which only his physician can effectively administer will do much toward helping him maintain his physical and social equilibrium.

ALBERT A. BRUST, M.D.

ATLANTA *Greets The*

'SOUTHERN'

Some 2,000 physicians will visit Atlanta this month to attend the 47th Annual Meeting of the Southern Medical Association which will be held at the Atlanta Municipal Auditorium. An event as important to Georgia medicine as this calls for further comment.

Atlanta, host to the Southern Medical Association is honored to be chosen as the 1953 meeting site. With expanded and modernized facilities, "The Gate City of the South" is becoming the convention city of Dixie. Atlanta's geographic location makes it the natural crossroads of the entire Southeast. Its moderate climate along with the charm of Atlanta hospitality never ceases to impress out-of-state visitors.

Ranking among the leading medical centers, it will be no new experience for Atlanta to welcome physicians of the Southern Medical Association. Within

the Atlanta metropolitan area alone there are 1,011 physicians, 2450 graduate nurses, 14 general hospital and nine related institutions with a total of over 4,000 beds. The 14 clinics in the area have over 450,000 visits annually. Certainly the members of Southern will feel at home among their Georgia colleagues.

The Fulton County Medical Society was chosen as host to the Southern Medical Association Meeting and welcomes members of the Southern. The Society has striven to make this meeting a memorable success both for its scientific contributions and for its pleasant, friendly entertainment.

And the Medical Association of Georgia with its 95 component medical societies in the state of Georgia extends a hearty welcome to the Southern Medical Association at its 47th Annual Meeting.

Service INSURANCE

for

HOSPITALS

The need for competent personnel, (nurses, technicians, hospital attendants, aides, etc.) has prompted the Public Relations Committee of the Medical Association of Georgia to sponsor a traveling exhibit of photographs depicting hospital people at work. The purpose of the collection of some 50 photographs is to interest and encourage the young people of Georgia in entering this field of work. This objective would insure hospitals of adequate personnel to enable them to best serve the citizens of Georgia.

The exhibit, photographed by Dr. Ted F. Leigh, covers many phases of hospital work showing trained specialists performing their various duties. Entitled "Faces of the Hospital," the photographs are a pictorial display of the hospital staff in action.

This display was part of the exhibit of the Medical

Association of Georgia at the Southeastern Fair Association (Fair-A-Ganza) in Atlanta, October 1-11. Future plans for the exhibit call for its display at high schools and public libraries throughout the state of Georgia.

If hospitals are to attract the calibre of personnel necessary to staff and fill existing needs adequately, a program of recruitment must be effected. By sponsoring an exhibit of this nature which will be shown on a statewide basis, the Medical Association of Georgia is actively working toward this end.

DID YOU KNOW?

That in the State of GEORGIA in the year 1952 there were one hundred and twenty-eight MATERNAL DEATHS. That from this number of pregnant women who died, forty-eight died as a result of HEMORRHAGE. Forty-eight women who became pregnant, forthwith gave up their lives as a result of hemorrhage during the course of the pregnancy or delivery.

Were these forty-eight deaths necessary?

Were these mothers-to-be through lack of proper PRENATAL CARE not aware of some of the danger signs during pregnancy? Was the COMMUNITY at fault in not having available adequate facilities

to care for these emergencies? Was there a hospital but no BLOOD? Was the PHYSICIAN or MIDWIFE in charge not aware of the seriousness of blood loss?

Prenatal care, community, blood, physician, midwife, hemorrhage, death.

Doctor!!!! This is your problem. Do you think that forty-eight pregnant women in 1952 should have died because of hemorrhage? What can you do in 1953 to reduce this number?

Maternal Welfare Committee of
The Medical Assn. of Georgia

Report on Grievance Committees

Just off the presses is a detailed report on county medical society grievance committees. Prepared by the AMA's Council on Medical Service, this study deals with the organization, functions and operations of 198 mediation committees throughout the country.

To make the data of more practical value, the societies have been divided into groups according to size. Copies of the booklet are available from the Council.

CYRUS C. STURGIS, M.D., Ann Arbor, Mich.

Some Recent

ADVANCES *in* HEMATOLOGY

First, let me thank you for the privilege of giving the Abner Wellborn Calhoun lecture. I am grateful for the opportunity to pay homage to the memory of an accomplished physician, a fine citizen, a valiant soldier, a churchman, an educator, and above all a gentleman who loved his fellowmen and labored unceasingly to increase their health and happiness.

He exemplified, in addition to his scientific ability, an important aspect of medicine which is perhaps now less well developed than it was some years ago, the wane of which has given me some concern as a medical teacher. I refer to the decline of the art of medicine. This phase of practice has been defined by Harvey Cushing as the ability of a physician to win the confidence of his patients and their relatives. To accomplish this, he continues to say, requires on the part of the physician "an understanding of human nature, abounding unselfishness, unflagging sympathy, and observance of the Golden Rule." We all agree that it does not take the place of a substitute for scientific training but it should be used daily to the fullest extent by every physician in his practice. In this present-day world, with its amazing development of science, there appears to be a regrettable lack of emphasis on this valuable and essential phase of medicine for which there can be no substitute.

Hence I salute the memory of Abner Wellborn Calhoun for he not only practiced medicine in keeping with the best scientific knowledge of his time but also daily in his work did those things which made him master of the Art. Thus these accomplishments made so appropriate the classic inscription on his tomb "The Great Physician." There can be no finer epitaph for a member of our profession.

Now, let me turn to the main topic of my address—"Some Recent Advances in Hematology" which, I hope, will be of use to you in your daily practice from a scientific standpoint.

The Incidence and Main Types of Anemia

Some years ago in the study² of a large number of routine admissions to the University of Michigan

*From the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan, Ann Arbor.

The Abner W. Calhoun lecture given May 12, 1953, before the General Session of the Medical Association of Georgia, Savannah, Georgia.

Hospital, both in-patients and out-patients over 14 years of age, it was found that 12.5 per cent or about one in eight patients had an anemia, according to the following standards: the lower limit of hemoglobin for males was considered to be 13.4 grams per 100 c.c. or 86 per cent and for females, 12.2 grams per 100 c.c. or 78 per cent. Furthermore, it was estimated that about 41 per cent of the patients had an iron deficiency anemia and 39 per cent had a simple chronic anemia which was normocytic, normochromic in type and was most commonly due to a chronic infection and less frequently to renal disease. A large percentage of the patients, therefore, had an anemia resulting either from a deficiency of iron or from a chronic infection. The remaining, smaller group had one of the other types of anemia among them being pernicious anemia, aplastic anemia, hemolytic anemia, sickle cell anemia, and other well-recognized varieties.

Simple Chronic Anemia

This type of anemia is usually mild as the red blood cell count is usually between 3.0 and 3.5 millions per cubic millimeter and the hemoglobin about 60 to 70 per cent (9.9 to 11 grams per 100 c.c.). The erythrocytes are of normal size and contain the average amount of hemoglobin. The cause of this type of anemia is chronic infection in about 95 per cent of the patients. The most common site of such an infection is the urinary tract, but it may be a chronic non-tuberculous pulmonary involvement, rheumatoid arthritis, acute rheumatic fever, chronic osteomyelitis, chronic active pelvic inflammatory disease or one of many others.

One type of interest is due to a mild urinary infection most commonly observed in middle aged women who complain persistently of vague and diverse symptoms which are usually classified as neurotic in nature. The importance of the anemia as a factor which contributes significantly to this clinical picture is often overlooked. If the urine is cultured and the etiologic cause determined, then the sensitivity of the organism to various forms of therapy such as the different antibiotics can be determined, and often the patient relieved of many of the complaints.

There is no specific cure for such an anemia. Iron,

vitamin B₁₂, liver, and other types of oral or parenteral medication are of no avail. The cure is to determine the site and nature of the infection responsible for the anemia and eliminate it, if possible by appropriate therapy. The only other form of treatment is blood transfusions. These may be given if the anemia is severe, and it is not possible to remove or control the cause.

The other important cause of such an anemia is renal disease, usually of an advanced type. In my experience, such an anemia is rarely observed unless the non-protein nitrogen is elevated above normal. This usually indicates that an inorganic acidosis is present which may be a contributing cause for the change in the blood. The patients may be improved considerably by the administration of blood transfusions until the hemoglobin and red blood cell count are normal. In a few patients, I have given potassium carbonate, 1.0 grams orally, t.i.d. on the basis that the acidosis may be helped and an improvement result in the anemia.

Iron Deficiency Anemia

Iron deficiency anemia is of great importance because it occurs with great frequency, the presence of achromia of the red blood cells makes its recognition easy, and it can almost always be corrected by the oral administration of a simple and inexpensive iron preparation.

From an etiologic standpoint, by far the most common cause is chronic hemorrhage either from the gastrointestinal tract or from the uterus in the female. Bleeding from the gastrointestinal tract is usually in small amounts and hence not observed by the patient. This may occur from esophageal varices, peptic ulcer, cancer of the stomach or large bowel, chronic ulcerative colitis, polyps in the stomach or colon or from hemorrhoids. Occasionally repeated epistaxis may be responsible for such an anemia.

When a patient has an anemia and the cells are observed to be achromic and usually with an average cell size which is below normal, then one should suspect strongly that the patient has an iron deficiency, and as has been previously emphasized by others, the indication is "FIND THE HEMORRHAGE." If there is no evidence of bleeding from the gastrointestinal tract then, in the case of females, one should suspect excessive uterine bleeding. It should be emphasized that although a female patient may insist that her menstrual periods are perfectly normal, she may be losing three or four times more blood during each period than the average woman.

There may be other contributing etiologic factors to such an anemia but they are usually minor as compared to chronic hemorrhage. Among these are a low intake of iron as observed in infants who are receiving a diet of milk exclusively; chronic infection; an achlorhydria which lessens the absorption of iron; periods of rapid growth and repeated pregnancy; and possibly an inadequate intake of ascorbic acid which lessens absorption as emphasized by Moore and associates.¹

When an anemia is present, therefore, in which the red blood cells are achromic as verified by a mean corpuscular hemoglobin concentration below 30 per

cent, and often in the vicinity of 25 per cent, and by a low color index, approaching 0.5, one should suspect chronic hemorrhage as the etiologic basis for it. Such an anemia could, however, be present in Mediterranean anemia (Thalassemia, Cooley's anemia, Erythroblastic anemia) which is almost exclusively limited to persons of the Mediterranean countries, and is a rare condition in the United States. This type of anemia may also be observed in an appreciable number of patients with Hodgkin's disease, although this is a fact which has not received sufficient emphasis. Neither of these latter varieties are improved with iron therapy.

Treatment of Iron Deficiency Anemia

The treatment of patients with an iron deficiency anemia is usually a simple matter. It consists in giving an adequate dosage of iron and controlling the hemorrhage. It has been my practice for a decade or more to give enteric coated tablets of ferrous sulphate 0.3 grams (five grains) t.i.d., a.c. for a period of two weeks. If the hemoglobin has not increased at the anticipated average rate of about one per cent daily in this period, the dose is then doubled.

There is no evidence to indicate, in my experience, that the addition of copper, or other metals, liver, vitamin B₁₂, stomach products, or any other substance will enhance the therapeutic activity of the commercial preparations of iron, unless it is ascorbic acid when the patient is deficient in this vitamin, which is rarely the case.

If the dosage of iron given above does not produce the desired therapeutic results within two weeks, then I suspect: (1) that the medication is not being taken as prescribed; (2) that the patient does not have an iron deficiency; (3) that bleeding is so excessive that hemoglobin is lost in greater quantities than it can be formed, even in the presence of an adequate amount of iron.

Rarely in my experience has the patient complained of important untoward symptoms due to iron medication. If they are present then iron can be given following or with meals; the ferrous sulphate preparation can be discontinued and ferrous gluconate given in doses of 0.6 grams (10 grains) t.i.d., p.c. and reduced in accordance with the patient's tolerance. In an extremely small number of patients, it may be necessary to administer iron intravenously. This can be given as saccharated oxide of iron, 100 milligrams intravenously (five c.c.) slowly over a five to 10 minute period every day or on alternate days. Such a dose will increase the hemoglobin about four per cent. If a patient has a hemoglobin of 50 per cent, and it is desired to raise it to 90 per cent, then five c.c. (100 milligrams) can be given daily or every other day for a series of 10 doses or until a total of 1000 milligrams has been injected.

It is well to keep in mind also, especially in the extremely rare patient who reacts adversely to oral iron medication, that a blood transfusion has a two fold value. Namely, it provides hemoglobin which is already formed, as 500 c.c. of blood will raise the hemoglobin of the circulating blood about 10 per

cent. Furthermore, 500 c.c. of normal blood contains about 250 milligrams of iron which is of course helpful in regeneration of hemoglobin in such patients.

Macrocytic Anemias

The macrocytic anemias with a megaloblastic bone marrow are a small but important group of blood disorders because highly effective specific therapy is available for them. It has now been 27 years since Minot and Murphy reported that cooked or raw liver in amounts varying from one-half to a quarter of a pound per day would completely control the anemia of Addisonian pernicious anemia. In the intervening years, it has been discovered that the active principle is vitamin B₁₂ or cyanocobalamin, a crystalline bluish-red substance containing 4.5 per cent of cobalt. This material may be isolated from liver and also is formed by the growth of certain microorganisms such as several of the streptomyces group.

It is now generally accepted that Vitamin B₁₂ is the active principle found in liver extract; that the only normal function of the intrinsic factor in the stomach is to expedite the absorption of this vitamin; that vitamin B₁₂ is a complete treatment of pernicious anemia as it affects favorably the anemia, the neurological changes, and the glossitis; and that the most practical method of administration is by intramuscular or subcutaneous injection, although in large doses it is absorbed from the stomach, and it is effective when given by inhalation and also by nasal instillation.

There are a number of additional macrocytic anemias which differ materially from pernicious anemia but in which the antipernicious anemia drugs are effective. The most important of these are tropical and non-tropical sprue, the macrocytic anemia of pregnancy, and the macrocytic anemia of infancy and childhood. The anemia is macrocytic in type and the bone marrow is megaloblastic, and in all there is a response to folic acid, five to 10 milligrams either orally or parenterally. It is inadvisable to use folic acid alone, however, in the treatment of pernicious anemia for while the anemia is controlled, it does not benefit the neurological manifestations and some believe that it may actually cause them to progress. In a few patients with pernicious anemia, however, in whom the red blood cell count does not reach normal limits with vitamin B₁₂ therapy, it is permissible to add five milligrams per day (orally) of folic acid to the vitamin B₁₂ medication, as this will usually cause the blood to return to normal promptly. Folic acid, however, should never be given to patients with pernicious anemia as the sole form of therapy.

In the treatment of the pernicious anemia of pregnancy, it should be kept in mind that vitamin B₁₂ is ineffective whereas folic acid produces prompt and satisfactory results. It is known that vitamin B₁₂ or folic acid alone may control the anemia of both tropical and non-tropical sprue but better and more certain results are obtained when they are used in combination. The megaloblastic anemia of infancy and childhood may respond to vitamin B₁₂, but the preferred treatment is oral folic acid; it is considered

to be advisable by some to give also 100 to 200 milligrams of ascorbic acid daily. The nutritional macrocytic anemia both in the temperate zone and tropics may show some response to vitamin B₁₂ but folic acid is the therapy of choice.

The Dose of Vitamin B₁₂

It is generally considered that one microgram of vitamin B₁₂ is approximately equivalent to one unit of liver extract. When vitamin B₁₂ or liver extract is used, it should be given to an adult in a dose of 15 micrograms or 20 units subcutaneously daily for one week; then three times weekly until the red blood cell count is 3.0 million per cubic millimeter and then twice a week until the erythrocyte value is normal. A maintenance dose of 15 to 20 units or micrograms may then be given every 15 days or approximately 30 units or micrograms every 30 days. These are average doses which are adequate for a great majority of patients. Larger doses may be required for some, especially if any type of infection is present. The main objective is to keep the red blood cell count well within normal limits, because if this is done the spinal cord changes of pernicious anemia will not progress, and if they have not been present for more than one year, they may improve markedly. Although larger doses will do no harm, there is no reason to inject more than 50 units of vitamin B₁₂ at one time as it is probable that when a larger amount is given, it is excreted in the urine and wasted.

There is probably little difference in the therapeutic effects between vitamin B₁₂ and refined liver extract. Both are complete forms of therapy. Two to three per cent of patients who receive liver extract, however, develop some allergic manifestations to it, usually following long continued treatment; rarely if ever does such a complication follow the use of vitamin B₁₂.

Recently vitamin B₁₂ combined with an extract derived from animal stomach mucosa, thought to contain the intrinsic factor, has been introduced in the treatment of pernicious anemia. From a theoretical standpoint this should prove to be an effective form of oral therapy, and the results so far are encouraging. On the other hand, the preparation needs a more thorough trial as the intrinsic factor is susceptible to heat and may be partially destroyed in the process of manufacture. Furthermore, all oral preparations raise the question of constant and complete absorption. Further clinical studies on such preparations, however, may demonstrate that they are reliable and effective.

Anemia of Pregnancy

There are four main types of anemia associated with the gravid state which are easily recognized. The first is a pseudo-anemia (the physiological anemia of pregnancy) due to an increase in the total blood volume which begins early in the first trimester of pregnancy and reaches its maximum in the third trimester. This is maintained until shortly after delivery. The increase in total plasma volume causes a dilution of the red blood cells and hemoglobin of the circulating blood and when the maximum dilution

of about 25 per cent occurs, the red blood cell count may fall to 3.5 millions per cubic millimeter, and the hemoglobin to 10.0 grams per 100 c.c. of blood or 64 per cent. The actual number of erythrocytes and the total amount of hemoglobin in the entire human body, however, remains within normal limits. It should be kept in mind, therefore, that during pregnancy, unless the hemoglobin is less than 10 grams per 100 c.c. (64 per cent) or the red blood cell count is below 3.5 million per cubic millimeter, it cannot be said that a true anemia is present. This pseudo-anemia does not cause symptoms and without therapy corrects itself within a few days following delivery.

In our experience, between 25 and 30 per cent of all women have a true anemia during the course of pregnancy, although in many instances it may be mild in nature. With rare exceptions such an anemia is one of two types, namely, a commonly occurring microcytic hypochromic anemia due to a deficiency of iron, and a second much rarer variety, a macrocytic anemia which is probably due to a folic acid deficiency. At least it responds promptly to folic acid therapy.

From a practical standpoint, therefore, one should determine *first*, during pregnancy, if an anemia is present which is greater than the physiological anemia; *second*, is the anemia of the hypochromic, microcytic type which responds promptly to iron medication; *third*, is the anemia of the rarer macrocytic type, the so-called "pernicious anemia of pregnancy" which responds to folic acid medication but is refractory to vitamin B₁₂ therapy; and *finally*, is the anemia a coincidentally associated one which has no relation to the gravid state, such as pernicious anemia, aplastic anemia, sickle cell anemia, the anemia associated with leukemia, and in fact any anemia which may occur in non-pregnant women.

The treatment in the latter group of patients depends on the nature of the anemia. Those with pernicious anemia may be carried successfully through pregnancy and deliver a normal fetus at term. Those with aplastic anemia may be supported with blood transfusions but it is thought by some that a therapeutic abortion is indicated as a means of prolonging life. Occasionally patients with leukemia may carry the fetus to term successfully but in all such patients, exposure to the roentgen rays should be avoided to avert possible fetal injury.

ACTH and Cortisone in the Treatment of Hematologic Disorders

The therapeutic use of ACTH and cortisone is of importance in the following hematologic disorders: (1) idiopathic thrombocytopenic purpura; (2) acquired hemolytic anemia; (3) acute and subacute leukemia; (4) multiple myeloma; (5) and lymphoblastoma.

In patients with idiopathic thrombocytopenic purpura, the injection of 25 milligrams of ACTH subcutaneously every six hours or the oral administration of 75 milligram doses of cortisone at the same interval will produce improvement without fail. During the administration of either one of the preparations, the sodium intake should be limited in order to

prevent the accumulation of edema. This is best done by placing the patient on an 800 milligram sodium diet. If this is not feasible, then all obviously salty food should be eliminated from the diet, and the use of the salt shaker prohibited.

Such patients, in relapse, during the period of active bleeding, have a reduction in the circulating blood platelets to below 75,000 per cubic millimeter and often they are completely absent. With this form of treatment, the platelets are restored to normal numbers or at least to the level where the bleeding is controlled after 10 to 14 days of such therapy. Having controlled the hemorrhagic tendency, there is a partial or complete relapse in about 60 per cent of the patients when the therapy is discontinued. A second course, however, will produce another satisfactory remission which permits splenectomy without the hazard of pathologic bleeding. This operation apparently cures about 60 to 80 per cent of all such patients.

The treatment with such therapy when successful in producing a prolonged remission, cannot be said to have cured the patient, but at least a remission of long duration is induced. Further observations over a period of years is necessary before a definitive answer is available regarding this. The longest cure which we have observed has been three and one-half years.

Idiopathic acquired hemolytic anemia, although still a rare disorder, appears to be increasing in frequency. Until recently the only treatments of benefit were blood transfusions and splenectomy, the latter being effective in about 60 per cent of the patients. Blood transfusions were sometimes associated with untoward reactions which in some instances deprived patients of the beneficial effects of such a procedure.

Shortly after the introduction of ACTH and cortisone, it was observed that either drug in the proper dosage would almost invariably induce a remission in the hemolytic process and cause the blood to return to normal within a few weeks. The doses which we employed in each instance, along with sodium restriction, were the ones advised in the treatment of idiopathic thrombocytopenic purpura.

After a remission has been induced, the therapy should then be omitted and the patient observed. In all but about 20 per cent of our patients, there was a relapse within a few weeks. The preparation was then given for another course, a second remission induced, and the spleen removed which resulted in a cure in about 60 per cent of the patients.

In one patient observed recently, apparently blood was being hemolyzed at an exceedingly rapid rate because 18 transfusions of 500 c.c. each, given over a period of 21 days, failed to increase the red blood cell count significantly. Cortisone and ACTH therapy were completely ineffective. When several transfusions of 1500 c.c. each were given within several days, the red blood cell count rose to approximately normal, and splenectomy was performed with gratifying results.

It can be concluded, therefore, that in almost all patients with acquired idiopathic hemolytic anemia,

there is a satisfactory but usually a temporary remission induced by either ACTH or cortisone which at least permits splenectomy under safer conditions. In only about 20 per cent is the improvement of such a duration to be regarded as a prolonged remission or possibly a cure.

Leukemia

Arsenic in the form of Fowler's solution was the first form of treatment for leukemia. It was only moderately effective and consequently was replaced by the roentgen ray which was introduced for this purpose in 1902. Since that time it has become generally established that the latter form of therapy produces a favorable effect in patients with chronic myelogenous leukemia and chronic lymphatic leukemia. My own opinion is that usually the total body type of irradiation is more satisfactory in patients with chronic myelogenous type and localized therapy is preferable in the chronic lymphatic type. It is more convenient for the patient but probably no more efficient to substitute radioactive phosphorus (P-32) in the treatment of chronic myelogenous leukemia but often this is not available.

There is some difference of opinion concerning this but it is my belief that although these therapeutic agents produce prompt, striking, and worthwhile temporary improvement in both of these main types of leukemia, it is difficult to prove that they prolong life. Nevertheless, all patients with either of these varieties of leukemia should be treated with roentgen irradiation, or in the case of myelogenous leukemia with radioactive phosphorus if this is available. In addition, they should receive blood transfusions and antibiotic or sulfonamide therapy in order to control the infection, chiefly of the mucous surfaces, which almost invariably appears. It is gratifying to observe the prompt response to treatment, even though it is transient. Furthermore, while the average length of life of such patients is between 2 and 3 years, I observed one patient with chronic lymphatic leukemia who survived for 25 years, and some patients with chronic myelogenous leukemia survive for as long as 10 years or more from the onset of symptoms.

Treatment of Acute and Subacute Leukemia

One great difficulty in the past has been the lack of effective therapeutic agents which are useful in the control of the acute and subacute forms of the disease. In recent years, however, promising forms of treatment for these types of the disease have been introduced. Furthermore, the indications are that in the immediate years to come, further favorable progress will be observed.

The introduction of the folic acid antagonists which in some manner interfere with the growth of the abnormal leukocytes in acute leukemia was the first drug of this type to be used. Others which produce a similar effect are triethylene melamine (TEM) and more recently 6-mercaptopurine (Six MP). In general, it can be said that in almost one-half of the children with acute leukemia and about one-third of the adults, the folic acid antagonist preparations will induce a remission which persists for a few weeks to several months. Often a second and sometimes a third remission may be produced

by their action. In some instances, when such patients apparently become refractory to one type of medication, they remain sensitive to another form of treatment. The results attained with triethylene melamine are similar, and those following the use of 6-mercaptopurine are even more promising, but further studies are necessary for a definitive evaluation.

Of great interest also is the striking temporary improvement in patients with leukemia which follows the use of ACTH and cortisone. In some patients with acute and subacute leukemia, all evidences of the disease disappear for as long as several months.

These new forms of treatment, although productive only of temporary improvement, have promise, and it does not seem too optimistic to state that in the near future new and similar but more efficient preparations will be made available.

Treatment of Multiple Myeloma

Of special interest is the progress which has been made in the temporary control of multiple myeloma which is now considered to be a form of leukemia designated as subleukemic plasma cell leukemia or plasmocytic myeloma. It has been found that urethane in doses of 0.3 grams (five grains) in enteric coated tablets, t.i.d. p.c., with an increase in the total dose of 0.3 grams (five grains) each day until tolerance is reached or a total of 3.0 grams (45 grains) is given, will often control the symptoms of this condition and produce convincing objective evidences of improvement. In my experience, however, doses of this drug which are adequate to control the symptoms may also produce disagreeable gastric irritation. Another form of therapy which is effective in the control of the bone pain associated with this condition, especially of the spine, is the use of irradiation. I have also observed considerable relief from the use of cortisone in doses of 75 milligrams every six hours for a period of 14 days, with a gradual reduction in the dose, over a period of four to five days, followed by a continuation of about 50 milligrams daily thereafter, or an equivalent amount of ACTH may be used. Patients may continue to take such a dosage for a considerable period of time without untoward effects provided they are placed on an 800 milligram low sodium diet.

Treatment of Hodgkin's Disease

The treatment of Hodgkin's disease and allied conditions consists in the localized use of roentgen therapy in an attempt to control all evidences of the disorder. When a refractory state is reached, nitrogen mustard in courses of 8 milligrams intravenously every other day for three days may be used at intervals, and repeated blood transfusions given as indicated. Triethylene melamine orally has been employed in some patients, but I am not convinced that it is superior to nitrogen mustard and the toxic dose appears to be close to the therapeutic one.

After the patient becomes resistant to the above therapeutic agents, then ACTH in doses of 25 milligrams four times daily or cortisone 75 milligrams orally every six hours, may be employed. Such therapy will produce a certain desirable euphoria

and a sense of well-being, often an increase in appetite and some decrease in the size of the enlarged lymph glands. It appears, therefore, that after the standard forms of therapy have ceased to be effective, cortisone and ACTH deserve a trial. Recently one of our patients, a 16 year old boy who received such treatment, developed a ravenous appetite and gained 42 pounds of body weight, with striking clinical improvement for a period of about six months.

Cortisone or ACTH may also be of value in patients who have severe reactions to nitrogen mustard.

If one or the other is given standard doses for a period of several days prior to this form of therapy, there is less likelihood that untoward reactions will be produced.

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CARCINOMA *of the* STOMACH

The results in the treatment of cancer of the stomach have been uniformly bad in spite of the fact that it is and has been one of the common diseases affecting men in particular. In contradistinction to cancer of the lung in which the incidence has increased steadily during the past 25 years, cancer of the stomach has always been a frequent cancer of men. In fact, since the time of the ancients cancer of the stomach has been one of the most frequent cancers encountered. It has been stated¹⁰ that over 40,000 deaths occur in the United States annually from cancer of the stomach. According to Berkson and his coworkers² one in every 200 patients admitted to the Mayo Clinic has a gastric cancer.

For some reason, the incidence of gastric carcinoma in the South is somewhat lower than in other parts of the country except among negroes. In 1947, the number of gastric cancers per 100,000 population in negroes was 36.6 per cent as compared with 23.5 per cent for white persons.⁵ For the same year, the total incidences of gastric cancer for both negroes and whites in the San Francisco and Alameda Counties and in Denver were 30.6 and 26.9 per cent, respectively. In the Charity Hospital in New Orleans,

gastric carcinoma occurred in 1 in every 265 admissions.⁴ The incidences of gastric carcinoma for negroes and whites in the Charity Hospital series were one in 279 for the white persons and one in 258 for negroes. If the obstetrical patients were excluded, the incidences were one in 277 in white persons and one in 197 in negroes. In the Ochsner Clinic, the incidence of gastric malignancy among all patients admitted was one in every 555.¹²

It is reasonable to assume that in a condition which occurs as frequently as gastric cancer, relatively good results could be obtained by therapy. This is particularly true because gastric cancer has been a frequent lesion for many centuries and does not represent a new lesion. However, the results from therapy have been far from satisfactory and there has been a tremendous variation in the operability incidence in various series. Allen¹ and Clark⁶ report an operability incidence of only 50 per cent. On the other hand, an operability incidence of 88.9 per cent was reported by Bocharov.³ In a series of cases admitted to the Ochsner Clinic, 76.6 per cent were operated upon.¹² The above statistics are based on cases admitted to large institutions, and obviously the incidence of operability would be considerably less if one considered all the cases in a particular metropolitan area as Clark⁶ did in the Metropolitan area of Houston, Texas in which only 30 per cent of all cases of cancer of stomach were operable.

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The resectability incidence also varies according to different statistics, from a low of 25 per cent reported by Clark⁶ to a high incidence of 54 per cent reported by Winkelbauer.¹⁷ In the total cases occurring in a large metropolitan area studied by Clark, only 5.7 per cent were resected. In any malignant condition in which only a third or less of the patients can have a surgical extirpation, the end-results are bound to be bad. This is illustrated by the fact that the five-year survival rate following treatment of gastric cancer is extremely low, ranging from five per cent to approximately 10 per cent. In all the cases in the metropolitan area reported by Clark, the five-year survival rate was 0.8 per cent. In our series, the five-year survival rate was 10 per cent.

Obviously, in any condition as common as gastric cancer in which the results following definitive therapy are as poor as they have been in this condition, a reevaluation of the problem becomes necessary. The medical profession generally has been quite concerned about the ineffectiveness of therapy in gastric cancer and various suggestions have been made to increase the total five-year salvage rate. In the treatment of all malignant neoplasms, radical extirpation is obligatory, and because not infrequently recurrence occurs in the remaining pouch following subtotal gastrectomy, it has been suggested that all cases of gastric cancer should be treated by total gastrectomy. Stout¹⁴ in a series of eight cases coming to autopsy six or more months after subtotal gastrectomy, found local recurrence with no evidence of metastasis in three. Walters, Gray, and Priestley¹⁵, in a series of 120 cases of gastric carcinoma subjected to resection, found 40 in which there was recurrence in and about the stomach. McNeer and coworkers¹¹ found in a series of 92 patients coming to autopsy following gastrectomy for gastric carcinoma that there was local recurrence either in the wall of the stomach or at the gastric jejunostomy site in 46 (50 per cent). These authors further showed that in 60 cases in which it was possible to determine the extent of resection, there was local recurrence in 44 cases. Of these cases, seven (15.9 per cent) had less than one-fourth of the stomach resected; 15 (34.1 per cent) had one-half resected; 20 (45.5 per cent) had from one-half to three-fourths resected, and only two (4.5 per cent) had more than three-fourths resected. In other words, 42 (95 per cent) of the 44 cases in which local recurrence occurred had only three-fourths or less of the stomach removed. *Obviously, any resection of the stomach for malignant neoplasm which removes less than three-fourths of the stomach is an incomplete operation and can never be considered an adequate cancer operation.* It is, therefore, necessary to define what is meant by the operative procedure which is to be employed in the treatment of gastric cancer. Whereas a total gastrectomy means complete removal of the stomach with a portion of the esophagus and duodenum, a "subtotal" gastrectomy apparently can mean anything from a large "biopsy" to a radical cancer operation. If one elects to perform a subtotal gastrectomy, it must be a

radical procedure. We consider a subtotal gastrectomy as one in which the entire first portion of the duodenum and all the lesser curvature of the stomach up to the cardia is removed; removal of all the greater curvature up to within five or six cm. of the cardia; removal of all the gastrohepatic omentum, the gastrosplenic omentum, and the greater omentum; careful dissection of and removal of the lymph nodes along the lesser curvature, especially those around the celiac axis and the left gastric vessels, the subpyloric nodes, the subhepatic nodes, the gastrolinal nodes, and the paraesophageal nodes. In performing a gastrectomy for cancer, it is necessary to remove the first portion of the duodenum as well as the stomach although formerly it was thought that the duodenum was relatively immune to involvement from cancer. Coller and his co-workers⁷ found in a series of cases in which gastrectomy for carcinoma was done that on careful microscopic examination of the duodenum it was involved in 26.4 per cent. Similar results are reported by Harvey.⁸ Konjetzny⁹ found the duodenum involved in 67 per cent of his cases.

In malignant lesions involving the proximal half of the stomach, we believe that a total gastrectomy is necessary in order to remove all the cancer-bearing stomach. On the other hand, we are equally convinced that in lesions limited to the distal half of the stomach, as most gastric cancers are, total gastrectomy will offer no more than will the radical subtotal procedure described before. It must be emphasized that no procedure, either a radical subtotal resection or a total gastrectomy, is going to cure all gastric cancers, because far too frequently the lesion has extended beyond the stomach and even beyond the regional lymph nodes at the time the diagnosis is made. Although the remaining pouch of the stomach following a radical subtotal resection is extremely small, not much larger than a man's thumb, it is our experience that patients treated by this procedure get along much better and have fewer symptoms than individuals who have been subjected to total gastrectomy. It is questionable whether the small pouch following subtotal gastrectomy is responsible for the paucity of symptoms, because the reservoir resulting from esophagojejunostomy and jejunojejunostomy following total gastrectomy is certainly as large and many times larger than the gastric pouch reservoir following radical subtotal gastrectomy. We are of the opinion that because a small portion of the fundus of the stomach is left intact in the latter procedure, some of the left vagus fibers are intact and for this reason there are fewer symptoms.

In a series of 220 cases of primary gastric malignant lesions observed in the Ochsner Clinic from 1942 to 1952¹², 94.5 per cent were carcinoma, 2.2 per cent were leiomyosarcoma, 1.2 per cent were reticulum cell sarcoma, and 0.5 per cent each were lymphosarcoma and Hodgkin's disease. As in other series, the condition occurred more frequently in men, 70 per cent, as compared with 30 per cent in women.

The lesion in the carcinoma group was described by the pathologist as being diffuse in 65.8 per cent,

ulcerative in 23.8 per cent, and polypoid in 10.4 per cent.

In cancer of the stomach as in most malignant lesions, far too frequently the condition is not suspected until it is quite far advanced. Because the early manifestations of gastric cancer are so minimal and occur insidiously, they are likely to be disregarded and the condition is usually not considered until the classical textbook picture of gastric cancer develops, which is seen only in the advanced and usually inoperable stage. In the present series of 210 cases of gastric cancer, there was an average duration of symptoms of 7.8 months and an average weight loss of 24.9 pounds. In fact, weight loss was the most prominent manifestation and was present in 91.4 per cent of the patients. Pain occurred in 83.8 per cent, nausea in 59.5 per cent, tenderness in 53.8 per cent, anorexia in 52.8 per cent, simple vomiting in 50 per cent, palpable mass in 43.8 per cent, retention vomiting in 20 per cent, melena in 19.5 per cent, and dysphagia in 14.2 per cent.

Undoubtedly the early diagnosis of gastric cancer is extremely difficult. Little difficulty will be encountered in making a diagnosis if the condition is allowed to progress until it is far advanced as is true of most malignant tumors. It has been frequently stated that roentgenologic examination of the stomach will yield a positive diagnosis of gastric cancer in over 90 per cent of cases. In the present series, a roentgenologic diagnosis was made in 96.5 per cent, which might be considered by some as an excellent record. The fact, however, that over 95 per cent of the patients were diagnosed as cancer by the roentgenologist indicates that the lesion was large and far advanced. We are of the opinion that over 95 per cent of the patients were diagnosed as cancer by the roentgenologist indicates that the lesion was large and far advanced. We are of the opinion that when it is possible to make a diagnosis of gastric cancer clinically on x-ray examination the lesion is far advanced and that far too frequently it has extended beyond the stomach and is inoperable. The desideratum, therefore, is to make a diagnosis before the lesion becomes demonstrable as cancer on roentgenographic examination.

It has been suggested that mass roentgenography can be used as a screening technique for the detection of gastric cancer, but the number of cases detected in this way is not sufficient to justify its use. Roach and his co-workers¹³ found in such a survey that asymptomatic cancer or its precursors was found in only one of every 476 examinations.

The treatment of gastric cancer consists of surgical extirpation of the stomach and the regional lymph nodes before the lesion has extended beyond the stomach. In the series of 210 cases of gastric cancer reported here, 12.8 per cent were so far advanced when first seen that they were considered inoperable and were treated by non-operative palliative measures. In 183 (87.2 per cent) it was considered operable, of which seven per cent refused surgery or returned home to be operated upon. One hundred sixty-eight (80 per cent) of the entire group were ex-

plored. However, in 46.6 per cent of these cases the lesion was found to be non-resectable. In this group, 14.2 per cent died in the hospital. In 70 patients (33.7 per cent of the entire group) a resection was done. In 65 per cent of these it was termed a palliative resection. A palliative resection was considered one in which there was neither gross nor microscopic extension beyond the stomach or to the regional lymph nodes. In 46 patients in whom palliative resections were done, 76 per cent had subtotal gastrectomy, of whom 5.7 per cent died in the hospital. Four patients had esophagogastrectomy, two of whom died. Seven patients had total gastrectomy, three of whom died (42.8 per cent). The high mortality rate in the patients with esophagogastrectomy and total gastrectomy was due to the extent of the disease and not to the operative procedure. There were only 24 patients in whom resection was considered curative, because there was neither gross nor microscopic evidence of extension beyond the stomach. Twenty-one of these patients were treated by subtotal resection: 9.5 per cent died in the hospital. Three patients treated by total gastrectomy survived.

Forty-three and eight-tenths per cent of the entire group of patients had some type of palliative procedure, and 21.9 per cent were treated by palliative procedures other than resection, such as gastrojejunostomy and jejunostomy. Sixteen and seven-tenths per cent were treated by subtotal resection, 3.3 per cent had total gastrectomy, and 1.9 per cent had esophagogastrectomy. In 23.8 per cent exploration and biopsy were done. In 12.9 per cent the operation was not warranted, in 10 per cent curative subtotal resection was done, in 8.1 per cent operation was refused, and in 1.4 per cent curative total gastrectomy was done.

Long time survival rates are almost as important as immediate survival rates. In a consideration of the survival rates, it must be recalled that in the general population as a whole within the age group of the sixth and seventh decades in which these patients fall, the five-year survival rate is approximately 85 per cent. In the present study, although it represents a critical method of analysis, we have assumed that any patient not surviving a given period died of the disease. Obviously this gives a poorer outlook, but we believe it is justifiable, because the personal equation cannot enter into the calculation. In the group of patients in whom no resection was done, who obviously were the more advanced cases, 14.4 per cent were alive at the end of six months, 4.03 per cent were alive at the end of one year, and only one in a group of 109 (0.9 per cent) was alive at the end of two years. No patient lived three years. In all the patients in whom some type of resection was done, 38.9 per cent were alive at the end of five years. In the cases in which a radical subtotal resection was done, 47 per cent were alive at the end of five years. It is thus seen that the radical subtotal procedure gave as good or even better results than did the cases in which total resection was done. In the group of cases in which a palliative radical subtotal resection was done in patients with either gross or microscopic evidence of spread beyond the stomach, the five year survival rate was 20 per cent, whereas in the group

of cases in which there was no evidence of spread beyond the stomach or into the lymph nodes, the five year survival rate was 85.7 per cent.

Whereas it is generally considered that polypoid lesions of the stomach give a better prognosis than any other type of lesion, in the present series the best prognosis was obtained in patients with ulcerative lesions. Only 1.7 per cent of the patients with diffuse lesions lived as long as three years. Twenty-five per cent of the patients with polypoid lesions lived five years and 42.8 per cent of the patients with ulcerative lesions lived five years. Undoubtedly, in the present series, the higher incidence of five years survival rate in the group with ulcerative lesions is due to the fact that we believe all gastric ulcers should be operated upon; many of the ulcerative lesions were clinically benign but were found to be malignant only upon microscopic examination. In a series in which a larger number of such cases are included, relatively good results will be obtained in the ulcerative cases.

To summarize the results in the present series, exploration was done in 76.6 per cent and resection in 33.3 per cent. Twenty-nine per cent survived resection, and 9.9 per cent were alive at the end of five years.

Although a five year survival rate of only 10 per cent leaves much to be desired, it does represent a real advance over the usually reported five year survival rates of approximately five to six per cent. The present study demonstrates that as much can be accomplished by radical subtotal resection of the stomach in the treatment of gastric cancer as by total gastrectomy if one reserves the radical subtotal resection for those cases in which the lesion is limited to the distal half of the stomach. However, lesions in the proximal half of the stomach should be treated by total gastrectomy. Although the results in the present series are better than those usually reported, we are convinced that much should and can be done to improve these results. The fact that only 33 per cent of our patients had a lesion which was resectable illustrates that the diagnosis was made late in most of the cases. It is only through earlier diagnoses at a time when the lesion is still limited to the stomach when a salvage rate of over 75 per cent be obtained that material improvement in long-time survival can be secured. It is our conviction that if we continue to wait until individuals have symptoms and signs which are classical of gastric cancer, we are going to continue to get bad results in the treatment of the disease. It is only by institution of appropriate therapy at a time when the classical manifestations of gastric cancer are lacking that a significant increase in the five year salvage rate can be obtained. We are equally convinced that if one waits until a lesion can be diagnosed as gastric cancer on roentgenographic examination, considerable time will be lost and, when such evidence is present, the lesion is already far advanced. In order to improve the results in the treatment of cancer of the stomach, it is necessary

to treat lesions which clinically are not cancer. Although this may seem paradoxical, it means that lesions which are benign clinically should be treated as if they were cancer. All gastric ulcers must be excised, because many times it is impossible to determine by roentgenographic or gastroscopic examination, by the surgeon at the time of operation, or even after the stomach has been removed whether a gastric ulcer is benign or malignant. It is only after microscopic examination that a malignant neoplasm can be excluded or diagnosed.

Wilson and McCarty¹⁶, in 1909, found in a series of 153 cases of proved gastric carcinoma that there was evidence that the neoplasm developed from a preexisting ulcer in 71 per cent. Stout¹⁴ states that in 13.4 per cent of 82 cases in which gastrectomy was done for cancer there was evidence that the cancer had developed at the margin of preexisting benign ulcers. Although it is impossible to state conclusively that gastric ulcer does or does not undergo malignant change, it is not unreasonable to assume that such a possibility exists. Any epithelial surface which is so susceptible to malignant change as the gastric mucosa could easily, under sufficient stimulation, undergo malignant transformation. It is well known that a chronic ulcer on the skin or even a scar resulting from the healing of an ulcer becomes malignant (Marjolin's ulcer). Polyps which are definitely premalignant lesions are an indication for gastrectomy, and it is probable that there are certain cases of chronic gastritis in which gastrectomy should be done in order to prevent malignant change in the gastric mucosa.

Although the conditions mentioned represent definite lesions of the stomach, it is our conviction that certain cases of cancer of the stomach must be treated when it is impossible to demonstrate any gastric lesion. A man of 40 years of age or older who previously has had no digestive disturbances and who for the first time develops an anorexia severe enough to make him lose weight consistently must be considered as having gastric cancer until proved otherwise. The absence of positive laboratory findings, such as on roentgenographic examination, gastroscopic examination, cytologic examination, does not exclude the possibility of gastric cancer being present. We believe that such cases should be subjected to abdominal exploration in order to exclude or verify a diagnosis of gastric cancer. This is undoubtedly an extremely radical philosophy, but it is not as radical as it appears when one considers the extremely poor results that have been obtained and still are being obtained in the treatment of gastric carcinoma. If this philosophy is accepted, undoubtedly there will be instances in which an exploration will be negative. Although one should not condone an unnecessary procedure, it is far better to do an unnecessary abdominal exploration which proves to be negative than to wait until the lesion can be diagnosed as cancer and is likely to be incurable.

Summary

As long as medical records have been kept, gastric cancer has been a common lesion, particularly in

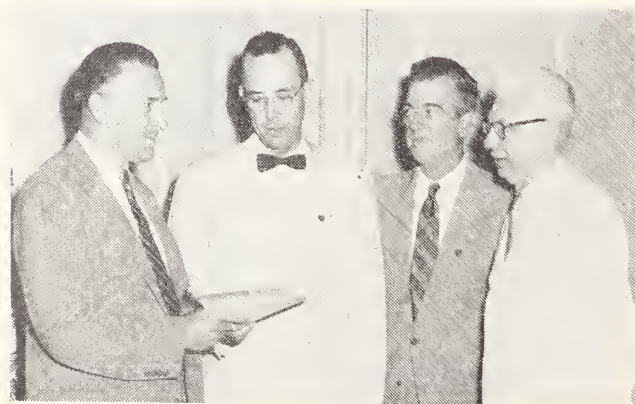
men. Unfortunately, however, the results from therapy have not been good in that in most cases only approximately five per cent of all patients with gastric cancer admitted to the better institutions are alive at the end of five years. Although total gastrectomy has been suggested as a possibility of increasing the salvage rate, it is our conviction that this procedure is not necessary in distally located lesions and does not offer a higher chance of cure. It is only by making a diagnosis when a lesion cannot be diagnosed clinically as gastric cancer that therapy has a chance of producing a cure. In the present series of cases, radical subtotal resection gave a five year salvage rate in over 75 per cent of the cases in which the lesion had not extended beyond the stomach. If all gastric carcinomas could be diagnosed and therapy instituted when the lesion is limited to the stomach, similar results could be obtained in all cases. In order to do this it is necessary to treat as cancer all lesions which are apparently benign and which are clinically not cancer. This is particularly true of gastric cancer, gastric polypi, and certain cases of chronic gastritis. In addition, it is necessary to resort to abdominal exploration in an occasional man who previously was well and free from digestive disturbances, but who after forty years of age develops an indigestion, usually consisting of anorexia which is sufficiently severe to make him lose weight. By adopting this philosophy, a definite increase in the salvage rate from gastric cancer can be obtained.

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Cardiovascular Research



Heart officials talk over plans for the establishment of Chairs of Cardiovascular Research at Georgia's two medical schools. Left to right are: Mr. Rome A. Betts, executive director, American Heart Association; Thomas L. Ross, Jr., Macon, retiring president, Georgia Heart Association; Eugene Ferris, professor of Medicine at Emory University and Edgar Pund, president, Medical College of Georgia, Augusta.

Chairs for Cardiovascular Research at Georgia's two medical schools were recently made possible by identical grants of \$12,000 to each school by the Georgia Heart Association. Occupants of the Chairs will be full-time faculty members of the medical schools and directors of research laboratories bearing the name of the Heart Association. The step has been hailed by local and national leaders as an answer to the problem of encouraging qualified men to devote careers to heart research. The Georgia Heart Association plans to repeat the grants on an annual basis.

It inaugurates what might be a new concept in the support of research in that it is an entirely cooperative arrangement between the schools and a voluntary health agency. Closeness of this cooperation is evidenced by the fact that the schools themselves are adding \$3,000 to the amount of the grant. The school will have full authority in the selection of the person.

The THERAPEUTIC Response of SURGICAL RESECTION *in* PULMONARY TUBERCULOSIS

A Study of 100 Cases

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Indications for Resection

As a general principle, an individual should be evaluated for surgical resection when he demonstrates a lesion that is considered nonamenable to collapse measures. This principle is intended to preclude those patients with minimal lesions showing satisfactory response under conservative management. Experience has shown that certain lesions with specific characteristics are best handled by surgical excision. In considering cavitational disease, the giant cavity with probable endobronchial involvement and the thick wall cavity with its zone of surrounding fibrosis, respond best to surgical extirpation. Medially placed cavities usually fail to obliterate with collapse measures and are best excised. Cavitory lesions of the middle and lower lobes present definite indications for excision. Surgical resection is indicated in individuals demonstrating persistent cavities not controlled by collapse measures. The residua of endobronchial tuberculosis, by their nature irreversible pathological processes, present definite indications for surgical resection. In this group, bronchiectasis and major bronchostenosis are the most common processes encountered. Fibrocaseous lesions involving a complete segment or an entire lobe deserve resection. The value of the removal of persistent sub-segmental fibrocaseous nodules needs further investigation before being classed

During the past five years surgical resection has been used with increasing frequency as the primary or as an adjunctive measure in the therapy of pulmonary tuberculosis. With the introduction of antibiotics, improvements in anesthesia, and with refinement in surgical technique, pulmonary resection has been carried out with reasonable surgical risk to the patient. This report is an analysis of 100 patients in whom resectional procedures have been performed.

An examination of vital statistics obtained from this group reveals that the age span was from seven to 70 years. There were 81 males and 19 females, and the majority of patients fell into the third, fourth and fifth decades of life (See Table I). In 30 of the patients, early elective resection was carried out as the primary therapeutic measure. The remainder of the group had lesions resected after demonstrating failure in response to other accepted forms of treatment.

TABLE I

100 CASES UNDERGOING RESECTION CORRELATION IN DECADES						
1-10	11-20	21-30	31-40	41-50	51-60	61-70
1	0	28	24	26	14	7
Age Span — 7 Years to 70						
Females 19				Males 81		

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as a definite indication for surgical resection. Expanding tuberculomas and those greater than 2 cm. in diameter present indications for their complete excision because of their potential for bronchogenic spread of tuberculosis.

Additional factors must be considered in the selection of patients for resectional procedures. Experience has shown that the patient with diabetes mellitus handles a concomitant tuberculous process poorly. It is felt that the excision of residual foci of infection offers this group of patients the best chance for permanent cure. Adult tuberculosis in children presents a specific indication for resection since thoracoplasty must not be performed before the completion of bone growth. A socio-economic demand for minimal thoracoplasty and a familial or racial history of poor immunological response to tuberculosis present additional factors that must be considered in the indications for surgical resection.

An analysis of patients in this group studied reveals the following indications for resection (Table II). Six of the 100 cases had demonstrable bron-

more advanced pathology, and endobronchial disease required a prolonged period of preparation. In this group, other adjunctive measures such as pneumoperitoneum and in some cases thoracoplasty, were carried out to produce satisfactory preparation of the patient for resection. Active endobronchial disease was found to be a definite liability to surgery, and when noted was treated with streptomycin. Endoscopic demonstration of bronchial health prior to surgery was achieved in the majority of those showing endobronchial tuberculosis. Conversion of positive sputum was found to be an indication that the postoperative convalescence would be more satisfactory, and this was obtained whenever possible. In some of the cases stability did not occur, and resection was carried out in an attempt to stop progression of the disease.

In this group of patients, 56 had received streptomycin therapy for a period of over 30 days prior to surgery. Fourteen received therapy for less than 30 days, and 30 patients had no preoperative streptomycin administered. Some of the earliest resections were performed without the benefit of preoperative streptomycin. Later, streptomycin was administered as a single antibiotic agent, and for the past four years streptomycin and PAS (para-aminosalicylic acid) were combined as antibiotic agents. In spite of preparatory therapy, 64 per cent of the patients had persistently positive sputum in the immediate preoperative period. In some cases, previously established adjunctive measures were continued. Many of the patients were maintained on pneumoperitoneum, and in several instances phrenic interruption had been carried out during earlier stages of the disease. At the time of resection five of the patients showed active endobronchial disease. Twenty-three cases demonstrated residua of previous endobronchial involvement.

TABLE II

INDICATIONS FOR RESECTION	
Bronchiectasis	6
Nodular-conglomerate lesions with irreparable parenchymal changes	
(a) Cavitory	32
(b) Without cavities	40
Thoracoplasty failures	5
Tuberculoma	5
Neoplasm suspected	9
Large blocked cavity	3
Total	100

chiectatic lesions. The majority of the resections were carried out in individuals who showed nodular or conglomerate lesions that involved at least a total pulmonary segment. Pathological study of the resected fibrocaseous lesion revealed that 32 were cavitory at the time of removal. Five cases were thoracoplasty failures. In five cases a tuberculoma greater than 2 cm. in diameter was found. Prior to thoracotomy a differential diagnosis between neoplasm and a tuberculous process could not be made in nine cases. Large blocked cavities that were unresponsive to antibiotic therapy were present in three patients.

Of the total group of 100 patients, 30 primary resections were performed. In nine of these 30 cases a neoplasm was primarily suspected, and the tuberculous lesion was excised at the time of thoracotomy. The remaining 21 represent early elective resection for pulmonary tuberculosis.

Preoperative Preparation

The general regimen of preoperative preparation consisted of bedrest and antibiotic therapy. The length of bedrest varied according to the individual's specific needs. The clinical progress, serial X-ray study, and the patient's past tuberculous history were used in establishing the optimal time for surgical intervention. Patients showing toxic manifestations,

Surgical Resection

The types of surgical resections utilized consisted of total pneumonectomy, lobectomy, segmental and sub-segmental (wedge) resections. In each case, the type of resection was selected on the basis of the immediate preoperative radiologic findings, the gross pathology at the time of thoracotomy, the patient's past history, and the preoperative evaluation of respiratory function. Statistically, 17 pneumonectomies, 77 lobectomies, 25 segmental resections, and 14 sub or partial segmental (wedge) resections were performed. This involved a total of 133 individual resections in 100 patients, with one patient having staged bilateral lower lobectomies for tuberculous bronchiectasis. When technically possible, an attempt was made to remove all areas of lung showing gross involvement. Modification of this principle occurred when preoperative pulmonary function study indicated that the individual might not tolerate the loss of the total area of involved parenchyma. In all instances the major focus of disease was resected.

The surgical technique employed was that of individual vessel ligation, meticulous coaptation of bronchial mucosa with fine silk sutures, and the avoidance of resection through planes of grossly

involved lung parenchyma. In the majority of cases, a pedicle pleural graft was fixed over the exposed bronchial stump. Gross contamination in the pleural space occurred in a limited number of resections. The three conventional operating positions were employed with approximately equal frequency. The supine or prone position was used when technically possible.

Postresectional Collapse Therapy

In 60 cases, some form of postresectional collapse therapy was instituted (See Table III). Small tailor-

TABLE III

POST-RESECTIONAL COLLAPSE THERAPY	
1. Tailoring thoracoplasty	
(a) Post-lobectomy	43
(b) Post-pneumonectomy	6
2. Phrenic crush	
(a) Post-lower lobectomy	7
(b) Post-pneumonectomy	1
3. Oleo thorax	3

ing thoracoplasties were carried out in 43 patients following lobectomy. Six of the pneumonectomies were followed by thoracoplasty. In seven of the lower lobectomies phrenic interruption and concomitant pneumoperitoneum were instituted in an attempt to obliterate the residual space. An oleothorax was utilized in three cases. In two of these patients pneumonectomies had been performed and due to their age and physical condition, this method of maintaining mediastinal position was employed. Although morbidity was increased with postresectional collapse procedures, there was no increase in the rate of surgical complications, nor were any surgical mortalities incurred. In those cases where purely segmental or wedge resections were performed, subsequent collapse therapy was not carried out. Postresectional thoracoplasty is indicated in those patients in whom one-third or more of the whole lung was removed. The presence of palpable or suspected residual disease is a further indication for subsequent collapse measures.

Postoperative Complications

In 101 thoracotomies, 22 postoperative surgical complications were observed to occur in 19 patients (Table IV). The most serious complication was

TABLE IV

POST-OPERATIVE SURGICAL COMPLICATIONS	
Wound infections	
(a) Tuberculous	3
(b) Non-tuberculous	2
Pulmonary infarction	1
Coagulated hemothorax	2
Broncho-pleural fistula	8
Atelectasis	6
Multiple complications in several cases	

that of bronchopleural fistula, which produced the greatest morbidity and mortality.

Major atelectasis, as a postoperative complication, was noted in six cases. Minor tuberculous wound infections were present in three patients, and non-tuberculous infections were noted in an additional two. Nonfatal pulmonary infarction occurred in a single case.

In an analysis of the patients developing bronchopleural fistulae, the following factors were noted. This complication tends to occur in the patient group manifesting more advanced lesions, and the majority (6) of these patients had heavily positive pre-operative sputum. In four of the cases developing bronchopleural fistulae, no preoperative antibiotic therapy had been administered. Five of the eight patients showed active endobronchial disease at the time of operation. Bronchopleural fistula is the result of poor wound healing, and the process is brought about by the same etiological factors that produce poor wound healing elsewhere in the body; namely, the presence of uncontrolled infection in or about the bronchus, a compromise of the nutritional blood supply, or closure of the bronchus under tension. Early recognition and immediate institution of treatment led to a decreased morbidity and mortality following this complication. Treatment consists of the early establishment of adequate drainage and the subsequent obliteration of residual dead space. In one instance, a bronchopleural fistula appeared following the installation of varidase to liquefy a coagulated hemothorax.

Mortality

The overall mortality was found to be five per cent. Deaths occurring within 30 days of surgical resection were listed as operative mortalities. Two deaths (or 2%) occurred in this group. Two late deaths resultant to uncontrolled tuberculosis occurred respectively on the 44th postoperative day and during the 44th postoperative month. An additional mortality was recorded during the 11th post-operative month; this was consequent to a concomitant primary pulmonary carcinoma. The tuberculosis in this instance had been controlled. In two deaths, the operative procedure was that of pneumonectomy. In the other three, a lobectomy had been performed. In three cases, bronchopleural fistulae were found to be the major complications leading to death. In one pneumonectomy, a fatal contralateral atelectasis occurred in the immediate postoperative period. Uncontrollable auricular fibrillation and cardiac failure was the precipitating factor in another mortality. In an analysis of the deaths, it is felt that the two late deaths due to bronchopleural fistula might have been avoided with earlier recognition of the process present and with the use of the antituberculosis drugs that are at present available.

Observations Following Resection

The average observation period for this group has been two and one-half years. The following results were obtained from an analysis of the postoperative bacteriological study on sputum and gastric secre-

tions obtained from these patients (Table V). Eighty-five patients were found to have remained bacteriologically negative from the time of resection. Two patients died within the immediate postoperative period (30 days). Three patients were found to have had one or two positive sputum specimens usually with upper respiratory tract infections during the first six months following surgery. These individuals have subsequently shown persistently negative specimens. In 10 cases the postoperative sputum studies were repeatedly positive during a portion of the

TABLE V
SPUTUM STUDY
100 RESECTED CASES

PRE-OPERATIVE			
POSITIVE		NEGATIVE	
64		36	
64%		36%	
POST-OPERATIVE			
NEGATIVE		POSITIVE	
		1 or 2 positive specimens	Repeatedly +
85		3	10
Surgical Survivors	95	13.7%	
Total cases	100	13%	

postresectional period. Two late deaths occurred in this group. Of the eight living cases of persistent disease, four were found to be reactivation either in the operative side (2 patients) or the contralateral lung (2 cases). Four of the eight cases developed spread of the disease process to areas of lung parenchyma that apparently were not involved prior to surgical intervention.

After reviewing the cases showing recurrent disease, several factors were felt to contribute to the reactivation process. In certain instances it was felt that there had been inadequate resection; however, basic physiological demands in some patients precluded total excision of the disease process. The patient's refusal to carry out postresectional collapse measures was considered the major factor in disease recurrence in two patients. In two cases, incomplete preoperative preparation was felt to be the primary cause of disease, postoperative persistence of a chronic non-progressive type of disease was evident, and it was thought that surgery contributed to the salvage of a seemingly hopeless individual.

Present Therapeutic Response

The therapeutic response of 100 patients undergoing surgical resection for pulmonary tuberculosis has been investigated and is presented in the following manner. It is noted that there are 95 survivors. In an attempt to place these patients in categories that evaluate their present condition, the following classes are presented:

CLASS I *Full Clinical Recovery*, which implies that the patient has been bacteriologically negative for at least 24 months and at the present time has unrestricted physical activity. Forty-six patients qualify for this group.

CLASS II *Apparent Clinical Recovery* indicates that the sputum studies have been negative for over 12 months and that the individual has unrestricted activity. Thirty-four patients are found in this group.

CLASS III *Patient Still Under Treatment*. This group is subdivided into two classes:

- A. Sputum negative—10 patients;
- B. Sputum positive—5 patients.

An analysis of the CLASS III sputum negative group reveals that three of the patients are completing rehabilitation programs and are not receiving any therapy except limitation of activity. Four of the other patients in this group previously appeared in this report under examples of reactivation of disease. Since reactivation, they have undergone additional surgical procedures, and at the present time are sputum negative and on a carefully supervised rehabilitation program. The remaining three patients are still on antibiotic therapy with a modified rest program because of the presence of stable contralateral disease at the time of surgical resection.

In Group B, CLASS III patients, the sputum remains positive in five cases. These five patients are found to have persistent recurrent disease at the present time.

Summary and Conclusions

One hundred patients in whom active tuberculosis was treated by surgical resection have been studied. The basic indication for resectional therapy is that the lesion is considered non-controllable or distinctly less controllable by temporary or permanent collapse measures. A specific description of the types of disease that fall into this category has been outlined. The 100 cases were analyzed in regard to their specific indications for resection. Conglomerate tuberculosis, extensive fibrocaseous lesions, certain types of cavitational disease, tuberculoma, and thoracoplasty failures were the most common indications for surgical extirpation. In nine instances, resection of tuberculous tissue resulted from exploratory thoracotomy required by undiagnosed lesions.

The details of preoperative preparation have been discussed. As a result of our experiences with these cases, the importance of adequate preoperative antibiotic therapy and the control of any active endobronchial disease is stressed.

Whenever possible, any patient undergoing the removal of lung tissue equivalent in volume to one or more lobes was given the advantage of a subsequent small tailoring thoracoplasty. In two instances when such a thoracoplasty was refused by the patient, a serious recurrence of disease in the superior division of the ipso-lateral lower lobe was noted.

The postoperative complications encountered in this group have been studied in detail. Bronchopleural fistula is considered to be the most serious

tuberculous complication. Inadequate preoperative chemotherapy, bacterial resistance to chemotherapy, and active endobronchial disease play a major role in the production of this serious complication. The importance of early recognition and treatment of this complication is stressed.

The overall mortality has been discussed. Two patients, or two per cent, died within 30 days of operation and constitute the actual operative mortality rate. The complications involved in these two instances consisted of massive contralateral atelectasis and severe cardiac arrhythmia. Bronchopleural fistula played a major role in the progressive fatal tuberculosis, producing two of the late mortalities. The 5th mortality was resultant to contra-lateral bron-

chogenic carcinoma with autopsy showing complete control of the pulmonary tuberculosis at the time of demise.

The therapeutic response of the 100 patients has been presented. Ninety per cent of the original patient group has achieved sputum conversion. Of the remaining 10 per cent, five are alive with persistent disease and five have succumbed. The causes for therapeutic failure have been discussed. In several instances, though positive sputum persists, it is felt that surgery has produced partial salvage of an otherwise hopeless case.

This study has impressed us with the advisability of two weeks of prophylactic antituberculosis chemotherapy prior to most exploratory thoracotomies for undiagnosed lesions.

Some Methods That Have Proved Useful
in the Beginning of PSYCHOTHERAPY
with NEUROTIC PATIENTS

JOHN WARKENTIN, Ph.D., M.D., Atlanta

A major obstacle encountered by physicians in the effort to treat neurotic and psychosomatic patients is the difficulty of initiating a satisfactory psychotherapeutic relationship with them. This paper is an attempt to describe attitudes and techniques which have proved useful in overcoming the patient's resistances to psychotherapy.

The training and experience of the physician provide him with a special aptitude and attitude for dealing successfully with patients suffering from emotional or functional illness. He has become aware of the importance of long-range goals, rather than the mere alleviation of symptoms temporarily. When the patient enters the office to say, "Doctor, I've had these nervous headaches for three years now, and you've just got to do something," the experienced physician can say with confidence, "I'm glad to work on this problem with you, but we must face the fact that you won't get over a chronic illness like that in a matter of a few days or weeks."

Read before the Symposium on Neuropsychiatry in General Practice at the 103 Annual Session of the Medical Association of Georgia, Savannah, May 11, 1953.

Another attitude of importance is to listen with the "third ear." In dealing with neurotics, the physician needs to depend heavily on his intuitive and clinical acumen to hear not only the actual statements of the patient, but to respond readily to the patient's unconscious language, what he or she says "between the lines." When the patient states, "I never was nervous till I got pregnant the first time," the physician may well answer to the effect, "I feel that your pregnancy must have bothered both you and your husband." It is this personal subjective sensitivity, more than anything else, which gives the neurotic patient the feeling that he is deeply understood here.

Finally, a third attitude which is necessary in treating the neurotic patient is a certain professional firmness, so that the physician is not overwhelmed by the patient's insistence on immediate short-range therapy. If the patient complains of insomnia, the doctor may order a small supply of sedatives, but at the same time tell the patient, "This medicine will give you some temporary relief, but you want to learn to sleep without sedation. Why don't we talk over some of the things which make people so tense that they can't sleep?" If the patient hesitates to

speak openly with the physician, it may be necessary on later office visits to deny firmly the patient's continued request for sedation by some statement such as, "I think it is time now that we stop just relieving your symptom, and look at what there is about your person that makes you afraid to sleep." Such a proposal to seek *permanent* improvement will eventually give the patient much more hope and emotional support than any form of palliative treatment.

In considering more specific methodology, the physician must be aware of the necessity of *not covering up anxiety* in the patient, but to insist on its full expression and treatment. Just as physical pain brings the patient to the physician for help with physical illness, so emotional pain (or anxiety) *motivates* the neurotic patient. If the patient were "anesthetized" too soon by reassuring and encouraging comments, this could work like a placebo for a short time, but the patient would remain just as sick as before. A false hope for quick cure will eventually only discourage the patient further. If a patient comes with vague complaints of indigestion, and no physical basis can be found, it may be wise for the doctor to say, "Now this is the kind of thing that we will not cure immediately, and it may worry you some more before you get better." The doctor may also add, "Indigestion can be caused by having to 'swallow' disagreeable experiences in everyday life. I think we might talk about them and in that way help you to be less upset."

Positive anxiety is essential to motivate the patient to go through with the effort of changing himself. Actually, there are two kinds of anxiety. *Negative anxiety* is a kind of futile, useless complaining, a blaming of people or situations around the patient. In contrast, *positive anxiety* leads the patient to focus his worries on the question, "What is the matter with the kind of person I am, so that I have these nervous symptoms?" This paper describes methods primarily applicable to patients with positive anxiety.

Perhaps the outstanding characteristic of the psychotherapeutic approach to a patient is a certain *directness and openness on the part of the physician*. This applies to the doctor's statement of his general philosophy. For example, he may say to the patient, "I am convinced that your functional illness *can* be treated successfully, but it is not like doing surgery on you; when we talk about your nervousness, *you must take the initiative* in discussing your feelings." The doctor may even explain to the patient, "I think that your anxiety is good, it will not hurt you, and I hope you don't become relaxed before you get really better." In this same connection it may be wise to tell the patient also, "People usually become somewhat more upset than they already are when we start talking about their nervousness, and that is all right, it may be necessary for you to get worse before you get better." As the patient is seen in successive interviews, the doctor may profitably express some of his own feeling responses to the patient, such as saying, "I like your increased air of self-assurance," or the doctor may express dislike, such as, "You have now discussed your difficult home situation several times, and it is beginning to bore me; couldn't

we talk more about some of the thoughts you have about yourself?"

Such directness requires a certain setting, or *isolation*. It has repeatedly seemed helpful to conduct the interview treatment in an office other than the one in which the patient was originally examined physically. It helps to arrange with the office nurse that there should be no interruptions during the interview, not even phone calls. This isolation of the psychotherapeutic situation is further increased when the conversation is increasingly limited so as to exclude consideration of the patient's problems as they pertain to situations outside the interview. For example, a young woman with insomnia rather promptly came to the conclusion that it was due to her unhappy relationship with her husband. As the interviews continued, and she was still blaming her husband for the entire difficulty, the doctor finally said, "I wish we could leave your husband out now, and just deal with *what there is about you* which has made for this difficult situation."

It requires considerable self-discipline on the part of the doctor to achieve this shift away from an interest in the situation, and to get a sharp *focus on the emotional problems* "within the patient's skin." Psychotherapy primarily involves treatment of an illness inside the body of the patient, just as does treatment of a physical illness. In order to get sufficient concentration of therapeutic effort, three more techniques seem helpful: (1) To emphasize that the discussion should center on the problem of how the patient *feels*, and *not so much on what the patient might actually do* in behavior. (2) To implement this by simply *not giving any direct advice* to the patient as to how to handle real-life situations outside the office. (3) To let the patient know, as the interviews continue, that it is *not necessary to be socially polite* in the office. In fact, when one doctor suggested to his patient, an elderly executive, "I think it would help if we were less polite to each other," the patient promptly replied, "You know, doctor, I wish that you would speak up more, because I have been too polite all my life and it has kept me from getting close to people." This simple understanding between doctor and patient resulted in a distinct improvement in the patient's emotional symptoms.

Conclusion

Whatever techniques may be employed by the physician, the one factor of greatest importance in helping the neurotic patient is an *assurance of the doctor's warm interest*, and a *determination to work with the patient to a successful conclusion* whatever the difficulties may be.

DISCUSSION

Dr. Leonard T. Maholick (Savannah): Psychotherapy often is a major operational undertaking. Dr. Warkentin has confined his remarks to the factors involved in making his initial incision. More than that, he is sharing with us his own findings which have come out of his experiences and he has done this in a remarkably simple, direct, down to earth, fashion. In general, my own observations have led me to similar conclusions.

However, I believe he should have prefaced his remarks with a few statements about the general aspects of psychotherapy. I should like to make explicit what is implicit in his paper. Psychotherapy, basically, is an emotional experience. The heart and soul of therapy lies in its being a new and

intense feeling experience and the more it becomes this, the more successful it will be.

Pain is an integral part of the process. The patient is in pain before he comes for treatment; he undergoes pain during treatment, and often suffers more pain in the recovery phases. Pain is associated with growth. Unlike most surgical procedures, however, the psychotherapist does not have a wide choice of anesthetics to use in alleviating pain. The main instrument he uses for this is his own "self" and his feeling for the patient. Dr. Warkentin describes this as being "an assurance of the doctor's warm interest and a determination to work with the patient to a successful conclusion." This is so important to the entire psychotherapeutic process that I believe he might well have established this point at the

very beginning of the paper as well as at the end. The physician is aware of the fact that old wounds exist in the form of buried feelings. In order to help the patient get well he must have the firmness and willingness to re-open these old wounds so that more effective healing might take place.

The therapist has at his command a scalpel which he must learn how to use delicately but firmly and effectively. This scalpel exists in the feeling and understanding of the physician for his patient. It is tempered by his experiences, training, and knowledge, as well as by his capacity to relate to his patients. It is also tempered by his understanding and use of himself, both professionally and personally. The more proficient the physician becomes in wielding his scalpel, the sooner his patients will begin to recover.

Pre- and Post-Operative

MANAGEMENT

One-Stage Total ADRENALECTOMY:

Report of Four Cases

THOMAS A. McGOLDRICK, JR., M.D., Savannah

This report presents our experience with the medical management of four patients undergoing one-stage total adrenalectomy for re-activated metastatic carcinoma of the prostate and with the long-range control of the adrenalectomized state.

It is important to underscore the fact that these complex cases can be brought to a successful conclusion only through the integrated efforts of a team, consisting of surgeons, internist, anesthetist, laboratory and specially trained nurses.*

Following the advent of cortisone, the past two years have witnessed a rapid evolution in the field of adrenal surgery. Various authors, Huggins,⁶ Harrison,³ Thorn,¹² Woiferth,¹³ and others,⁷ have reported over 50 successful total adrenalectomies performed for prostatic cancer, breast cancer and severe hypertensive disease. The first of these cases was reported in 1951 by Huggins⁶ and Thorn,¹² at about the same date our first patient (Case I) was operated on, and it is apparent that the experience in controlling these

patients during operation and afterwards has been largely gained in the short span of two years.

In 1945, in pre-cortisone days, Huggins⁴ reported four cases of metastatic carcinoma of the prostate treated by total adrenalectomy. The substitution therapy for these patients is outlined in Table I.

Two of the early patients died within 36 hours postoperatively, one in 11 days, and one remarkably survived 116 days, succumbing finally to adrenal insufficiency, a sufficient interval, however, in which to observe a decrease in phosphatase activity and a slowing in the rate of growth of the neoplasm. These patients died in adrenal insufficiency, in shock with hypotension and hyperpyrexia, and it is this sequence of events which is most to be guarded against in the the immediate postoperative period.

Selection of Cases

The four cases which form the basis of this report had far advanced reactivated metastatic carcinoma of the prostate. All were desperately sick and required frequent narcotics for the control of bone pain. In retrospect these patients should have been adrenalectomized at an earlier stage of the disease, and there is need today for clearer indications as to the optimum time for performing the operation. Attempts to follow the rise in acid phosphatase or

*The surgery in these cases was performed by Drs. Charles L. Prince and Peter L. Scardino, both of Savannah, Georgia. Read before the Clinical Session of the 103 Annual Session of the Medical Association of Georgia, Savannah, May 13, 1953.

TABLE I

1945

SUBSTITUTION THERAPY FOR TOTAL
ADRENALECTOMY

0 minus 1 day

D C A	5	cc. I.M.	10 A.M.
Adrenal cortex extract	5	cc. I.M.	6 P.M.
Adrenal cortex extract	5	cc. I.M.	10 P.M.

0 day

Adrenal cortex extract	10	cc. I.M.	6 A.M.
Adrenalectomy			8 A.M.
D C A	5	mg. I.M.	9 A.M.
Adrenal cortex extract	20	cc. I.V.	9 A.M.
Plasma	500	cc. I.V.	9 A.M.
Dextrose 5% in water	500	cc. I.V.	9 A.M.
Adrenal cortex extract	10	cc. I.M.	Each hour until 8 P.M.
Plasma	500	cc. I.M.	7 P.M.
Dextrose 5% in water	500	cc. I.M.	7 P.M.
Adrenal cortex extract	5	cc. I.M.	Each hour

0 plus 1 day

Adrenal cortex extract	5	cc. I.M.	Each hour until 8 A.M.
Plasma	500	cc. I.M.	8 A.M.
Dextrose 5% in water	500	cc. I.M.	8 A.M.
D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	Every second hour until 8 P.M.
Adrenal cortex extract	5	cc. I.M.	Every three hours until 8 A.M.

0 plus 2 days and 0 plus 3 days

D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	Every four hours

0 plus 4 days

D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	Every six hours

0 plus 5 days

D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	Every eight hours

0 plus 6 days

D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	Every twelve hours

0 plus 7 days

D C A	5	mg. I.M.	8 A.M.
Adrenal cortex extract	5	cc. I.M.	8 A.M.

Succeeding days

D C A	5	mg. I.M.	8 A.M.
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the increase in 17-keto-steroid excretion as early signals of reactivation have not been consistently successful.³ An important criterion in the light of present knowledge is the appearance of pain from reactivated metastases, since the most impressive results occur with relief of this symptom. Two of the patients in this group received a trial of cortisone therapy before operation was decided upon in an effort to suppress adrenal activity, and both experienced transient improvement in appetite and sense of well being, with partial relief of pain, but shortly relapsed into their original condition. It is possible that better results will be obtained with the use of larger doses of cortisone and more prolonged administration.

Pre-Operative Preparation Tables II and III

These patients were chronically ill, malnourished and underweight, all receiving large doses of narcotics, and general preoperative measures included the correction of anemia, hypoproteinemia, avitaminosis, and electrolyte imbalance in so far as possible. Routine preoperative digitalization was not used unless there was evidence of congestive failure. Originally, as seen in Table II (Adapted from Thorn¹¹) and Table III (Huggins⁶), it was felt necessary to give ACTH for two days preoperatively to obtain the maximum concentration of circulating steroids, and to supplement this with DOCA and added salt in the form of enteric coated tablets. Subsequent experience^{9, 2} has proven that this amount of medication was excessive, and reliance is now placed on the single injection of cortisone 100 mg. given 12 hours preoperatively. Our cases and those of others² have demonstrated that in the evolution of a standard regimen the trend has been toward less medication (Table IV).

TABLE II

ORIGINAL SCHEDULE. (Used in Case 1.) Adapted from Thorn et al. (Now considered over treatment.)

Op — 3 and op — 2 days	ACTH 10 — 25 mg. q. 6 h.
Op — 1 day.	ACTH q. 6 h.
	Cortone 100 m. 12 hrs. pre-op.
	Cortone 50 mg. 2 hrs. pre-op.
Op — day.	200 cc. continuous aqueous adrenal cortical extract during operation.
	Neosynephrin 10 mg. in 1000 cc. saline titrated for hypotension.
	Whole blood for refractory hypotension.
	Start 50 mg. cortone q. 8 h. post op.
Op + 1 day.	Cortone 50 mg. q. 8 h.
	Sod. chloride 8 gm. daily (2-3 days).
Op + 2 day.	DOCA 1-2 mg. daily as needed for blood pressure.
Op + 3 day.	Gradual reduction of cortone dosage, ultimately to 25 mg. or 12.5 mg. daily.

TABLE III

REVISED SCHEDULE (Use in Case 2). Adapted from Huggins and Bergenstal.

Op — 1 day.	Cortone 50 mg. q. 6 h.
	DOCA 5 mg. (one dose).
	Sodium chloride 5 gm.
Op — day.	Cortone 150 mg. pre-op and 50 mg. q. 6 h. post-op.
	DOCA 5 mg. (one dose).
	Fluids and blood; nor-epinephrine for acute hypotension.
Op + 1 day.	Aqueous extract not used.
	Cortone 50 mg. 5. 6 h.
	DOCA 5 mg. (one dose).
	Sod. chloride 3 gm. (by mouth).
Op + 2 day.	Cortone 50 mg. q. 12 h.
	DOCA 3 mg. p.r.n.
	Sod chloride 3 gm.

Gradual reduction steroids to maintenance dose.

TABLE IV

NEW SCHEDULE. (Used in Case 3 and 4). (Note reduction in medication.)

Op — 1 day.	Cortone 100 mg. 12 hrs. pre-op. ACTH and DOCA not used.
Op — day.	Cortone 100 mg. pre-op. Aqueous extract not used. Neosynephrin or nor-epinephrine for hypotension. Blood and fluids.
Op + 1 day.	Cortone 50 mg. q. 6 h. Cortone 50 mg. q. 6 h. Sod. chloride p.r.n. DOCA not always necessary post op.

(Note expense much less). Protection adequate.

TABLE V

CURRENT SCHEDULE. Adapted from Harrison

<i>Op-minus 1 day</i>	Cortisone 100 mg. 12 hr. pre-op.
<i>Op-day</i>	Cortisone 100 mg. pre-op. Hydrocortisone (compound F.) I.V. infusion 10 mg./hr. during op. and for 6 hrs. after. Cortisone 50 mg. q. 6 h. Need for pressor agents less when I.V. compound F. used.
<i>Post-op</i>	Gradual reduction cortisone. DOCA if needed Salt 3-8 gms. O.D.

TABLE VI

MAINTENANCE THERAPY

1. Cortisone average 37.5 mg. daily.
2. Salt 4-6 gms. O.D. Varies with weather, activity, diuresis, weight.
3. DOCA linguets 2 mg. O.D.
Trimethyl DOCA (long acting) q. 4-5 weeks.
4. Protect during intercurrent stress, infections, operations, etc.
5. Continue estrogens.

Protection During Operation Tables II, III and IV

The patient is given 100 mg. cortisone intramuscularly on arrival in the operating room. In Case I, an intravenous infusion of 200 cc. aqueous adrenal cortical extract was maintained during the operation, whole blood was administered, and neosynephrin was used to combat hypotension. Severe hypotension following removal of the second gland was not encountered in any of these patients. In subsequent cases the use of aqueous extract has been abandoned and control maintained by intramuscular cortisone,

whole blood and intravenous neosynephrin or nor-epinephrine. Evidence now indicates³ that Hydrocortisone (Compound F.) in intravenous infusion at the rate of 10 mg./hour during operation and for six hours following effectively prevents immediate reaction to removal of the second gland. With improved technique, the operating time has been reduced from four hours in Case I to one and one-half hours in Case IV. The patients had sodium pentothal and cyclopropane anesthesia.

The Immediate Postoperative Period

The patient requires constant supervision during the first 24 hours; the blood pressure and pulse are checked every ten minutes and the temperature every half-hour. DOCA 5 mg. is given during this period and cortisone 50 mg. every six hours. Fluids and blood are given as indicated with care being exercised not to overload the circulation. The patient loses only a moderate amount of blood during surgery and large amounts of replacement blood and fluid are not required. Cases I, II and IV had mild hypotensive and febrile reactions during the first 24 hours and these were adequately controlled by intravenous neosynephrin or nor-epinephrine and aspirin. Case III had an uneventful postoperative course. Cortisone and salt are gradually reduced during the second and third days. When intravenous Hydrocortisone (Compound F.) is used, the infusion is continued for six hours postoperatively. Routine anti-biotics are administered. The marked sodium diuresis which occurs during the first ten days postoperatively is adequately covered by four to six gms. of salt daily.

The Maintenance Program Table VI

The average maintenance dose of cortisone has been found to be 37.5 mg., slightly higher than was originally considered necessary, and the patients are instructed in their absolute dependence on the daily ration. Additional table salt is added to the diet with supplementary enteric coated salt tablets as required, in amounts that vary with fluctuations in body weight, perspiration in hot weather, unusual physical activity or excessive diuresis. The patients require about four gms. of additional salt daily and the problem of salt excess has not been encountered, since the patients learn to reduce the amount at any sign of edema or sudden increase in body weight. The use of DOCA varies from patient to patient and has not been required regularly in any of our cases. In general it may be stated that the use of DOCA is governed largely by the blood pressure and appearance of edema, patients with hypertension or normal tension not requiring the drug, while those with hypotension and particularly postural hypotension will require it.⁵ When used it may be administered in the form of two mg. DOCA linguets twice a day, or the long acting trimethyl DOCA in dose of 30 to 45 mg. intramuscularly may be administered every five weeks.³ When in doubt, the addition of DOCA to the regimen does not appear to have harmful side effects as long as the appearance of edema and hypertension are watched for. There seems to be a wider margin of safety in the use of salt and DOCA

in patients who have been adrenalectomized for metastatic prostatic cancer than for those operated on for hypertensive disease,³ the latter requiring a more meticulous adjustment of the dosage. It is surprising how well our patients were able to maintain themselves merely on one and one-half tablets of cortisone daily and the addition of generous salt to the food. Hypoglycemic reactions have not been encountered and there have been no significant derangements in potassium metabolism. No increase in skin pigmentation has been observed.

The adrenalectomized patient, while in apparent good health, has no reserve, and is protected from crisis by the slender margin of a daily dose of cortisone. Any intercurrent stress, infection, operation, trauma, even diarrhea, may precipitate a crisis and this must be met immediately with increased medication. (One of our patients had a mild pharyngitis in the morning and in six hours a temperature of 105°.) The patients are instructed as one would a diabetic in the nature and seriousness of reactions. They carry with them at all times an extra supply of cortisone, salt tablets, and a broad spectrum anti-biotic, together with a letter to any physician called, explaining the nature of the case and an outline of suggested therapy for crisis. In general this includes cortisone increased to 200 mg. daily, intravenous saline, DOCA and anti-biotics. It is remarkable that there have been so few instances of crisis in these patients. There have been no fatalities due to adrenal insufficiency.

REPORT OF CASES

Case I.—O.W., a white man 52 years of age, was admitted to the hospital on November 2, 1949, complaining of pain in the lower extremities and back, exertional dyspnea, anorexia and loss of weight. There were no urinary symptoms. Following extraction of two teeth, uncontrollable hemorrhage occurred which required multiple blood transfusions and specific vitamins. Hematological studies revealed a marked suppression of hemopoietic system as reflected in red blood cells, 1.86 million; hemoglobin, 40 per cent; bleeding time, 4 minutes, 30 seconds; clotting time, 5 minutes 20 seconds; prothrombin time, 22 with control 20; platelet count 19,000. Examination revealed an extensive carcinoma of the prostate which on rectal examination was fixed, stony hard, nodular and irregular, with extension into the seminal vesicles and base of the bladder and protrusion into the rectal lumen without perforation of the rectal mucosa. The anus only partially admitted the examining index finger. The acid phosphatase was 3.3 Bodansky units. A complete radiological survey revealed no bony abnormalities of the skull, but there were metastases compatible with metastatic prostatic carcinoma of the lumbar vertebra, pelvis, shoulders and femur. Following multiple blood transfusions, estrogenic therapy and bilateral orchiectomy on December 12, 1949, the patient gained weight and became free of pain, but required intermittent multiple blood transfusions. After one year, the bone pain recurred and he again required large doses of narcotics. In spite of increasing the estrogen dosage and the institution of cortisone therapy (100 mg. daily) the patient continued to lose weight and increasingly large doses of opiates were necessary. Bilateral adrenalectomy was performed on July 11, 1951. The patient had a moderately severe febrile and hypotensive reaction during the first 24 hours which responded to substitution therapy. There was complete freedom from pain and discontinuance of narcotics on the tenth day. The patient gained 45 pounds in weight

and returned to work and normal activity. The blood picture returned to normal. Bone x-rays remained unchanged. After nine months, there was a return of bone pain and a general deterioration, and the patient died ten months after operation in congestive heart failure.

Case II.—G.B., a 57-year-old white man, was admitted to the hospital on September 5, 1951, complaining of anorexia, weight loss, general malaise, back pain, increasing constipation with frequent smaller caliber stools and marked rectal tenesmus. There were no urinary symptoms. In January 1949, following preoperative estrogen therapy in an attempt to reduce the size of the local prostatic lesion, the patient underwent radical perineal prostatectomy elsewhere.^{1,8} He was maintained on small amounts of estrogens. Histological examination of the excised prostate revealed an undifferentiated carcinoma with local extension. The patient escaped from the effects of estrogen therapy and underwent bilateral orchiectomy on April 12, 1950, to which he responded satisfactorily for approximately 12 months. A relapse occurred following which the patient received TACE¹⁰ which produced a very brief remission. His rectal symptoms however again became intolerable as did the back pain which resulted from a pathologic compression fracture of the first lumbar vertebra. Rectal examination of the prostate was difficult due to the encroachment of the local lesion upon the rectal ampulla. The rectal mass was huge, stony hard, irregular, nodular and fixed. The acid phosphatase was 2.5 Bodansky units. Roentgenologically there was a compression fracture of the first lumbar vertebra without other demonstrable metastases. Having escaped all available forms of anti-androgenic therapy, the patient underwent bilateral total adrenalectomy on September 10, 1951. There was a mild febrile and hypotensive reaction during the first 24 hours. There was considerable prompt relief of back pain and a gradual cessation of rectal symptoms. Also, the local lesion regressed slowly in size and softened. The improvement was never particularly striking although following operation the patient required smaller doses of opiates. The acid phosphatase decreased temporarily to 2.0 Bodansky units only to rise in two months to 3.8 Bodansky units. He was discharged from the hospital on September 24, 1951. Follow up examinations revealed continued regression of the rectal lesion, but there was moderate bone pain which was not as severe as before the adrenalectomy. The patient expired in cardiac failure elsewhere in January 1952, four months following the adrenalectomy.

Case III.—J. S., a 50-year-old negro, was admitted to the hospital on October 3, 1951, complaining of excruciating pain in the sacro-iliac region, and lower extremities; weight loss of 20 pounds, general malaise and anorexia. The diagnosis of prostatic carcinoma had been made originally in June 1951. At that time the patient was placed on estrogenic therapy. He later escaped from the effects of estrogens and underwent orchiectomy in January 1951. A brief remission of symptoms of approximately three months was experienced following orchiectomy and estrogen therapy but again he escaped anti-androgenic therapy and experienced a recurrence of bone pain requiring large doses of narcotics. Examination revealed an emaciated negro in acute pain. The prostate was nodular, fixed, stony hard, and there was involvement of the periprostatic tissues. Acid phosphatase determination was 7.4 Bodansky units. Radiological survey revealed saturation bone metastases involving all the vertebra and pelvic bones. In view of persistent downhill course and the failure to respond to conventional anti-androgenic therapy, the patient underwent bilateral adrenalectomy on October 5, 1951. His postoperative course was uneventful. He had an immediate response relative to pain which was objectively reflected in an acid phosphatase determination 20 days postoperatively of 4.4 Bodansky units. His appetite rapidly increased for a brief period, but concurrently he developed a paraplegia with urinary and fecal complications. An exploration of the ninth, tenth and eleventh dorsal vertebra on November 21, 1951 revealed encroachment of metastatic carcinoma upon the spinal cord. The patient again began to require massive doses of opiates. The acid phosphatase rose to 7.0 Bodansky units just prior to death in January 1952.

Necropsy: There was extensive carcinomatosis involving the prostatic area, with extension of undifferentiated prostatic

carcinoma around the seminal vesicles, into the base of the bladder and involvement of all vertebra and the entire pelvis.

Case IV—J. C., 60-year-old white male was first seen in August 1950 for carcinoma of the prostate with metastases to the lumbar spine and pelvis. Orchiectomy was done at that time and estrogenic therapy started. The response was good and the patient was seen at infrequent intervals for the treatment of mild congestive heart failure secondary to arteriosclerotic heart disease. In June 1952, 22 months after orchiectomy, there was a reappearance of the lumbar pain and weakness of the legs, with x-ray evidence of bone saturation metastases. The weakness progressed in a few months to paraplegia with frequent painful muscle spasms of the legs. Total adrenalectomy was done in October 1952. There was a moderately severe hypotensive and febrile reaction post-operatively. The patient had less pain postoperatively and required less narcotics, and the muscle spasm of the legs decreased. There was no apparent change in the paraplegia. The patient died in congestive heart failure three months after the operation.

Results

One patient was dramatically improved, two moderately improved, and one slightly improved following adrenalectomy. All were poor risk candidates for major surgery, yet all withstood the operation and the immediate postoperative period well. Three patients had mild hypotensive reactions with fever during the first 24 hours postoperatively but these were readily controlled, and after this period, no serious complications attributable to the adrenalectomized state were encountered.

Summary and Conclusions

The medical management of four cases of one-stage total adrenalectomy performed for reactivated metastatic carcinoma of the prostate has been described. Complete to partial relief of pain was achieved in all cases. With careful control the operation is safe, and the complications and mortality which ensue are those of the underlying disease and not of the adrenalectomized state. The patient without adrenal glands may lead a normally active life for an indefinite time while adhering to a simple maintenance program, and reactions of adrenal insufficiency due to stress, infrequent in our cases, respond promptly to a temporary increase in medication.

Total adrenalectomy is the only method of therapy in some otherwise hopeless cases of reactivated carcinoma of the prostate. There is need for better criteria to determine the optimum time for performing the operation, and there is a correlated need for investigation to determine why some patients seem to respond less well than others.

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SURGICAL CORRECTION

of

ACHALASIA *of the* ESOPHAGUS *in Infants*

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The paucity of references in the literature to achalasia of the esophagus in infants is note-worthy and therefore, it is felt it may be of merit to report a case which has been corrected successfully by surgery. This is a condition in which there is an obstruction at the lower end of the esophagus with dilatation and hypertrophy above. In 1882 Von Mikulicz¹² applied the term cardiospasm, but it is a misnomer and should not be used. The preferable term, achalasia, was coined by Hurst² in 1888 and is applied to this condition.

It is not the intention of this communication to review the literature on this subject since excellent reviews have been presented by Ochsner and de Bakey, Kay⁴ and others. In 1929 Messeloff⁵ stated that in over 20,000 x-rays of the G. I. tract which were made at Bellevue Hospital over a period of six years, only one case was reported and this was in a child of eleven. This case was relieved thirty minutes after injection of 1/150th grains of atropine on two occasions but the patient later expired following esophagoscopy. He also stated that a survey of the literature from 1879 to 1927 revealed only eleven cases. Messeloff⁵ was of the opinion that the disease was due to a functional disturbance of the vagus nerve.

Aikman in 1933 reported three cases in the newborn which were apparently relieved by frequent passage of a small catheter through the esophagus into the stomach and leaving it in place for several days at a time. Dr. Retan⁹ in discussing the paper presented by Aikman stated that he started the dilatation with a size 12 French catheter and passed one every twelve hours increasing it up to a size 28 and then once daily for a few days with good results.

H. J. Moersch⁶ reported 691 cases in 1929 but only 34 were in children with symptoms originating before the age of fourteen. Three cases had started before one year of age and were seen later at the age of 49, 34 and 28. Six of the patients he reported had had symptoms for 28 years. He also stated that the condition was sometimes confused with pulmonary disease since the patient would awaken suddenly at night with coughing and strangling due to the spilling over of esophageal contents into the trachea.

Vinson¹¹ states that to anyone who has had experience in treating patients with true achalasia the beneficial effect of catheters or dilators of fairly large size appears doubtful. He believes that so-called car-

diospasm is the result of temporary incoordination of the nerve and muscle mechanism of swallowing, and he reports a case in an infant seven days of age to support this opinion. Treatment in this baby was limited to concentrated food orally and adequate amounts of fluid subcutaneously. All medication was discontinued. Within a few days regurgitation of food ceased and the child appeared normal in every way. On recent examination 3 years after the original visit the patient was well and roentgenoscopic examination of the esophagus showed it to be normal.

Johnston³ reports another case that started abruptly at the age of two and was operated upon when nine years of age with an apparent cure. A Grondahl type of procedure was used in this case.

Many theories have been presented as to etiology of achalasia of the esophagus. The one which probably deserves most attention is the neurogenic theory presented by Rake⁸ in 1927, when he described the absence of or the degenerative changes in the cells of Auerbach's plexus in the lower esophagus. This produces muscular incoordination and normal swallowing is prevented. There is no abnormality of the region involved in this condition and it has been described as strikingly narrow and thin walled for a distance of one to several centimeters by Sweet.¹⁰ The area has also been described as being composed of "markedly hypertrophied circular and elliptical muscle fibers extending from the esophago-gastric junction upward for two to five centimeters,"⁴—by Kay and others.

REPORT OF CASES

P.L.M., white, female, age 6½ months, full term, weight 13 pounds 6 ounces was admitted to Crawford W. Long Hospital July 24, 1952. The mother stated that the baby had had difficulty with her formula ever since it was instituted. This was manifested by strangling and vomiting during and after each feeding. She gained weight normally for about the first three months. About six weeks prior to admission a barium swallow was reported as negative except for slow movement down the esophagus but the films were unsatisfactory due to the fact that the child had been fed before the examination. The symptoms continued with increasing severity and the baby lost 1¼ pounds during the last three weeks. She would not take her formula while lying down. The vomiting was not projectile and it was just as apt to occur while sitting up as when lying down.

FAMILY HISTORY: No childhood diseases. Patient has one eleven year old sister, living and well. Mother states that this child also had some difficulty with vomiting but gradually over-came it.

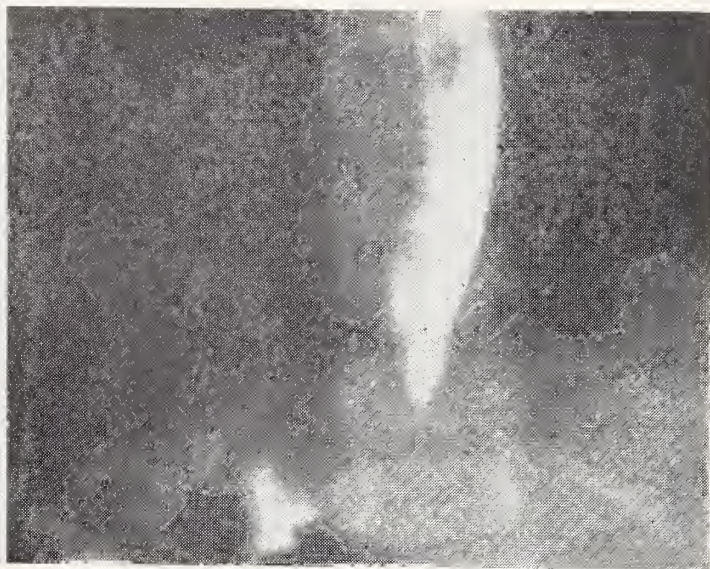


Fig. 1. Esophagrams which show an obstruction at the lower end of the esophagus with dilatation above.

PHYSICAL EXAMINATION: Temperature: 99°. Respiration: 26. Patient is a well developed, fairly well nourished white female infant whose skin has a mottled blue color. Lungs: rales at both bases, otherwise essentially negative.

LABORATORY: RBC: 4,200,000, Hemoglobin: grams 9.8 and WBC: 22,500.

URINALYSIS: Essentially negative.

OPERATIVE PROCEDURE, July 25, 1952: Bronchoscopy revealed no evidence of compression of the trachea or main stem bronchi and was considered negative. Then an esophagoscopy was done and a small amount of formula was found in the lower part of the esophagus. This material was sucked out and the lower end of the esophagus appeared to be much smaller than the proximal portion. No effort was made to insert the scope into the stomach. The lower end of the esophagus was dilated with a soft tipped esophageal bougie but it was felt that this dilatation was not very satisfactory. Achalasia of the esophagus was suspected and on July 26th a Lipiodol esophagram was done which revealed the presence of a definite achalasia of the esophagus. (See Fig. 1.) A small Levin tube could be passed through the esophagus and into the stomach and due to the fact that the baby had lost weight and was unable to retain any of the formula, the tube was left in place for feeding purposes. This tube was removed approximately two weeks later. At this time the child was placed on bentyhydrochloride and the formula was resumed by mouth. There was very little decrease in the regurgitation of each formula.

Several weeks later a small catheter was reinserted into the stomach through the esophagus and feedings were given through the catheter for approximately a week before it was removed. In October 1952, which was about three months after the first admission, the mother stated she would consent to surgery to have the baby's condition corrected. This had been advised sometime after the first admission. In order to prepare the child for surgery, a small catheter was passed through the esophagus into the stomach and she was fed through the tube for approximately two weeks before the operation.

OPERATIVE PROCEDURE, November 4, 1952: Anesthesia; nitrous oxide, oxygen and ether administered through a tight fitting mask with a Stephen's valve attached. An airway was used instead of an endotracheal tube. The chest was entered through the left seventh interspace and the posterior end of the seventh rib was cut in order to obtain adequate exposure. The mediastinal pleura was incised over the lower end of the esophagus and it was obvious that the

esophagus was definitely narrowed beginning just above the hiatus. The diaphragm was then opened and the stomach exposed. The phrenic nerve was not crushed. The lower end of the esophagus was dissected out and then a longitudinal incision was made through the serosa and muscular layers of the stomach and through the esophageal musculature down to the mucosa. An incision was made for a distance of approximately two centimeters on the stomach and approximately two to three centimeters on the esophagus. The stomach and esophagus were distended by the presence of air in both organs and it was observed that the narrowed portion of the esophagus was now much larger than it was before the incision. The thoracic cavity was irrigated with normal saline and then the mediastinal pleura was closed with interrupted silk sutures. The diaphragm was closed also with interrupted silk sutures so that only the tip of the little finger could be inserted through the hiatus along the side of the esophagus. The lung had been reexpanded every fifteen minutes during the procedure. A thoracotomy tube was brought out through the ninth intercostal space to be connected to a negative pressure bottle. The ribs were approximated with several interrupted catgut sutures, muscles were closed with running sutures of catgut and the skin was closed with a running lock stitch of silk. The baby withstood the procedure extremely well. A postoperative esophagram revealed a reduction in size of the esophagus and an adequate stoma between the esophagus and stomach (See Fig. 2).

POSTOPERATIVE COURSE: For the first three post operative days small amounts of milk were administered through the Levin tube. She was permitted to sit up and move about on the first postoperative day. On the third postoperative day the Levin tube was removed and the child was started on her formula which was gradually increased in amount. On the sixth postoperative day the baby was started on pureed vegetables and showed no difficulty swallowing water, formula or vegetables. She has continued to gain and now weighs twenty-two pounds. She has had no difficulty with regurgitation.

Discussion:

There seem to be 3 methods of treatment in achalasia of the esophagus in infants, and the simplest should be tried first. This consists of the administration of concentrated foods orally with maintenance of hydration by subcutaneous fluids. No medication



Fig. 2. Post-operative esophagram. There is no obstruction at the lower end and the esophagus above is reduced in size.

should be used. The second method to be tried is frequent passage of a small catheter which should be left in place several days at a time. If this is ineffective then dilators should be used. The third method employs the use of surgery consisting of a left thoracotomy and one of the various surgical procedures. The most radical consists of resection of the contracted lower end of the esophagus and a subsequent esophagogastrostomy. The one most frequently used has been a side to side anastomosis between the esophagus and cardia of the stomach but ulceration, fibrosis and hemorrhage have been reported in many of these cases, later necessitating

a resection and an esophagogastrostomy. The simplest of the surgical procedures certainly is the Heller technique which consists of incising the musculature of the esophagus down to the mucosa and the serosa and musculature down to the mucosa of the stomach for an adequate length in a longitudinal direction. Another popular technique is the Heineke-Mikulicz or Wendel procedure in which a longitudinal incision is made through all layers of the esophagus and cardia for adequate length and is closed transversely.

Summary

A case of achalasia of the esophagus in an infant with failure to respond to conservative therapy has been reported. This patient is probably the youngest on record to have surgery performed for this condition and it was corrected successfully by using the Heller technique.

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10. Sweet, Richard H.: In Discussion of Kay's Article: Observations As To The Etiology and Treatment of Achalasia of the Esophagus, J. of Thor. Surg., 22:254, 1951.
11. Vinson, Porter P.: Cardiospasm in the Newborn, J. Pediatrics 27:565, 1945.
12. Von Mikulicz: cited by Aikman, 1.

Rutledge Sends

for an M. D.

The doctorless community of Rutledge in Morgan County has raised \$3,750 to finance three years of medical education for medical student Edward Lev-erett who will practice for four years in Rutledge after his graduation from medical school. The community, which is nine miles from the nearest physician, thus becomes the first Georgia town to invest in a medical scholarship plan.

The plan worked out with L. R. Seibert, secretary

of the Georgia Medical Association Board, was sponsored in Rutledge by the local Lions Club. A recent editorial in the *Atlanta Constitution* stated, "For their health's sake, other doctorless communities should profit from the Rutledge initiative. Energetic Rutledge has lifted a voice that we hope will blossom into a full chorus of support for this program, the keynote of which is 'Act Now. Laggards are losers.'"

ANNOUNCEMENTS

OCTOBER 20: Spalding County Medical Society will meet at 6:45 p.m. at the Griffin-Spalding County Hospital, Griffin.

OCTOBER 20: Worth County Medical Society is scheduled to meet at 8 p.m. in Sylvester.

OCTOBER 21: Whitfield County Medical Society will meet at 7:30 p.m. at the Hamilton Memorial Hospital, Dalton.

OCTOBER 27: Polk County Medical Society will meet at 7:30 p.m. at the Wayside Inn, Cedar-town.

OCTOBER 27: Muscogee County Medical Society will meet at 7:30 p.m. at the Standard Club, Columbus. A "Ladies Night" program will be observed.

OCTOBER 27: Walker-Catoosa-Dade Medical Society will meet at 8 p.m. at the residence of Dr. E. M. Townsend, Ringgold.

OCTOBER 30: Georgia State Obstetrical and Gynecological Society will meet at 10:00 a.m. at Athens.

NOVEMBER 2: Cobb County Medical Society will meet at 7:00 p.m. at Kennestone Hospital, Marietta.

NOVEMBER 2: Telfair County Medical Society will meet at 8 p.m. at the Telfair County Hospital, McRae.

NOVEMBER 3: Upson County Medical Society will meet at 7:30 p.m. at the Upson County Hospital, Thomaston.

NOVEMBER 3: Tift County Medical Society will meet at 7:30 p.m. at the Tift County Hospital, Tifton.

NOVEMBER 3: Third District Medical Society will meet at 2:30 p.m.

NOVEMBER 3: Hall County Medical Society will meet at 7:30 p.m. at the Avon Restaurant, Gainesville.

NOVEMBER 3: Bibb County Medical Society will meet at the State Health Department or Pinebrook Inn, Macon.

NOVEMBER 5: Coffee County Medical Society will meet at 1 p.m. at the Douglas Hospital, Douglas.

NOVEMBER 5: Fulton County Medical Society will meet at 7:30 p.m. at the Academy of Medicine, Atlanta.

NOVEMBER 5: Ware County Medical Society will meet at 7:30 p.m. at the Ware Hotel, Waycross.

NOVEMBER 5: Fifth District Medical Society will meet jointly with the Fulton County Medical Society at 7:30 p.m. at the Academy of Medicine, Atlanta.

NOVEMBER 6: Jenkins County Medical Society will meet at 7:30 p.m. at the Magnolia Casino, Millen.

NOVEMBER 6: Chattooga County Medical Society will meet at 7:30 p.m. at the Chattooga County Hospital, Summerville.

NOVEMBER 6: Burke County Medical Society will meet at 7:30 p.m. at Millen.

NOVEMBER 9: Walton County Medical Society will meet at 7:30 p.m. at the VFW Home, Monroe.

NOVEMBER 9: DeKalb County Medical Society will meet at 7:30 p.m. at the DeKalb County Health Building, Decatur.

NOVEMBER 10: Altamaha County Medical Society will meet at 8 p.m. at the Appling General Hospital, Baxley.

NOVEMBER 10: South Georgia Medical Society will meet at 7:30 p.m. at the Country Club, Valdosta.

NOVEMBER 12: Jefferson County Medical Society will meet at 8 p.m. at the Jefferson Hotel, Louisville.

NOVEMBER 12: The Georgia Society of Anesthesiologists will hold a joint meeting with the Georgia Chapter of the American College of Surgeons at the Dempsey Hotel, Macon. Dr. Meyer Saklad of Providence Hospital, Providence, R. I., will be the guest speaker.

NOVEMBER 13: Randolph-Terrell Medical Society will meet at 8 p.m. at the Patterson Hospital, Cuthbert.

NOVEMBER 17: Spalding County Medical Society will meet at 6:45 p.m. at the Griffin-Spalding County Hospital, Griffin.

NOVEMBER 18: Whitfield County Medical Society will meet at 7:30 p.m. at the Hamilton Memorial Hospital, Dalton.

NOVEMBER 18: Tri-County (Calhoun-Early-Miller) will meet at 8 p.m. at Ft. Gaines.

NOVEMBER 18: Worth County Medical Society will meet at 8 p.m. at Sylvester.

NOVEMBER 19: Habersham County Medical Society will meet at 7:30 p.m. at Commercial Hotel, Cornelia.

NOVEMBER 19: Richmond County Medical Society will meet at 7:00 p.m. at the Old Medical College, Augusta.

NOVEMBER 19: McDuffie County Medical Society will meet at 8 p.m. at the McDuffie County Hospital, Thomason.

PERSONALS

Elizabeth Adams, of Atlanta, a resident in medicine at Emory University Hospital and her husband, *Charles T. Adams*, a senior at Emory University School of Medicine, were one of a dozen Atlanta husband-and-wife doctor teams featured in an article appearing in the *Atlanta Constitution*. Other couples, most of whom agreed that two practicing physicians in one family are "not too many" included *Lonis and Virginia Reynaud*; *Irving Greenberg and Regina Gabler* (her professional name); *Patrick and Rebekah Anders*; *Lester and Eleanor Petrie*; *Jean and Ted Staton*; *Lonis and Betty Schurter*; *John and Helen Slade*; *William and Ellen Kiser*; *Tom and Barbara Howell*; *Charles and Cordelia Dorman* and *John and Mary Schellack*.

William N. Agostas, of Augusta, has returned from the service and is practicing internal medicine in his new office at 1413 Gwinnett St., Augusta.

David A. Bagley, of Austell, was honored recently at commencement exercises of the University of Tennessee Medical Units in Memphis. He received a Golden "T" certificate.

Hugh Bickerstaff, of Columbus, and his wife, attended a meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons at The Homestead, Hot Springs, Va.

D. L. Butterfield, of Waynesboro, stressed the seriousness of tuberculosis in a speech before the Screven County TB Committee at the Community House in Sylvania recently.

Hal M. Davison, of Atlanta, has been elected a co-chairman of the Atlanta Round Table of the National Conference of Christians and Jews.

Thomas Florence, of Atlanta, will hold office hours in Marietta in the office of *Fred Schmidt* while the latter is on active duty in the Navy. Florence will practice urology in Schmidt's office, 206 Roswell Street, on Friday mornings and Monday and Thursday afternoons.

John W. Good, of Cedartown, was honored recently by the University of Tennessee Medical Units at commencement exercises in Memphis.

C. T. Hardman, of Tallulah Falls, has retired as physician for the Georgia Power Company plant at Tallulah Falls. He will continue his private practice in the community.

Sage Harper, of Douglas, was guest speaker at a recent meeting of the Coffee County Medical Auxiliary at the General Coffee Hotel in Douglas. His subject was "Know Your American Medical Association."

The following Georgia doctors took part in the annual meeting of the Georgia Orthopedic Society at Sea Island: *F. G. Hodgson*, Atlanta; *Ruth Waring*,

Savannah; *Jack Hughston*, Columbus; *Wood Lovell*, Atlanta; *Peter B. Wright*, Augusta; *Thomas Goodwyn*, Atlanta; *W. P. Barnes*, Macon; *William P. Warner*, Atlanta; *C. E. Irwin*, Warm Springs; *Paul L. Rieth* and *Sterling Jernigan*, Atlanta; *T. P. Waring*, Savannah; *H. W. Bondurant*, *Forrest J. Funk*, *Martin T. Myers* and *J. H. Kite*, all of Atlanta; *J. L. Candler*, Augusta and *W. A. Newman*, Macon.

Horace Joiner, of Douglas, has returned from a tour of active duty with the U. S. Navy and has reopened his office at the corner of Pearl and Sellers Streets, Douglas.

J. R. Lewis, of Louisville, has been named the outstanding citizen of Louisville by the Woodmen of the World. He receiving a plaque citing his long years of service in Jefferson County.

Bert Malone, of Brunswick, spoke on "Radiology" at a recent meeting of the Brunswick Kiwanis Club.

W. C. McCarver, of Vidette, who has served the people of his community in Burke County for 41 years was cited in an article in the *Waynesboro True Citizen*.

John M. McGehee, of Cedartown, has been named a Qualified Fellow in the International College of Surgeons.

Sam Patton, of Macon, has been named chairman of the Tuberculosis Christmas Seal Sale Campaign.

John Judson Pilcher Jr., of Wrens, will be associated with his father *John Judson Pilcher Sr.*, in the general practice of medicine.

W. P. Rhyne, of Albany, was principal speaker at a recent meeting of the Arlington Lions Club. His subject was "Sight Conservation."

W. A. Risteen, of Augusta, was recently awarded the Bronze Star medal for meritorious service performed with the U. S. Navy in the Far East.

John Robinson, of Americus, was honored recently by the Auxiliary to the Sumter County Medical Society at a picnic at the Lake Blackshear cabin of *Dr. and Mrs. A. C. Primrose* of Americus. Also honored were three new doctors on the staff of the Americus and Sumter County Hospital: *W. F. Bennett*, *E. W. Waldemayer* and *W. D. Anderson*.

Thomas L. Ross Jr., of Macon, past president of the Georgia Heart Association, presided recently at the Fifth Annual Meeting of the Association at the Hotel DeSoto in Savannah. *Clarence C. Butler*, of Columbus, and *Joseph C. Massee*, of Atlanta, presided at scientific sessions.

The engagement of Mrs. Mary Duke Biddle Trent of Durham, N. C., to *James Hinstead Semans*, of Atlanta, has been announced.

Charles B. Shiver, of Augusta, has opened offices for the practice of internal medicine at 1108 Druid Park Avenue, Augusta. *James W. Bennett*, also of Augusta, an instructor in pediatrics at the Medical College of Georgia, has his office for private practice

of pediatrics in the Newton Building.

Harlan Starr, of Rome, has resumed the practice of pediatrics with offices in the Harbin Clinic in Rome. He recently returned from a summer of post-graduate work at Harvard University and at the Children's Medical Center in Boston.

V. P. Sydenstricker, of Augusta, spoke recently at the Tennessee Valley Medical Assembly at Chattanooga, Tenn. His subject was "Collagen Diseases."

Henry H. Tift, of Macon, was one of nine Georgia doctors who addressed the Fifth Annual Scientific Assembly of the Georgia Academy of General Practice, October 16 and 17, at the Hotel Desoto, Savannah. Others included *David James*, of Atlanta, *Robert C. Major*, of Augusta, and *J. D. Martin*, *Steadman Glisson*, *Eugene Griffin*, *R. A. Bartholomew*, *William*

H. Kiser and *Joseph H. Patterson*, all of Atlanta.

J. P. Tucker, of Bainbridge, has been elected to the rank of Associate in the International College of Surgeons.

Luther H. Wolff, of Columbus, has been elected Sixth District representative on the Blue Shield Commission. The Sixth District consists of Louisiana, Mississippi, Alabama, Tennessee, Georgia, Florida, and Puerto Rico.

C. M. Westerfield, of Savannah, has been elected president of the Georgia Society of Anesthesiologists. Other new officers include *Lloyd Osteen*, Savannah, vice president; *A. J. Waters*, Augusta, secretary-treasurer; *Perry P. Volpito*, Augusta, delegate and *Lloyd Osteen*, alternate delegate.

DEATHS

DAVISON: *Thomas C. Davison*, 69, of Atlanta, died September 17 at his residence. A graduate of the old Atlanta College of Physicians and Surgeons in 1906, he served as chief of surgical services at Grady and Georgia Baptist Hospitals, was an associate professor of surgery at the Emory University School of Medicine and served as consultant to the Sheffield Cancer Clinic. He was a past president of the American Goiter Association and the Fulton

County Medical Society and was an honorary fellow of the International College of Surgeons. He was one of the founders of the Southeastern Surgical Congress.

HUSON: *William Joseph Huson*, 58, of Covington, died June 27 in Atlanta. He was graduated from the Medical College of Georgia, Augusta, in 1924 and served during World War I.

LOTT: *John J. Lott*, 71, of Broxton, died at Broxton August 8. He was graduated from the Gate City Medical College, Dallas, Tex., in 1903. He began practicing medicine in Georgia in 1910.

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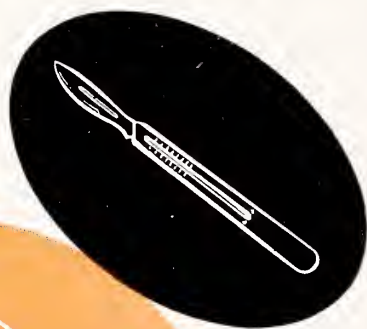
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The JOURNAL of the MEDICAL ASSOCIATION OF GEORGIA

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That old saying—the doctor's chair at the Thanksgiving table is always empty because he is out making calls—doesn't seem to apply to the practice-minded physician on our cover. This overworked M.D. has to ply his trade at home and on a holiday, too!

The illustration, by John Stuart McKenzie, Art Director, Foote and Davies, Atlanta, is the first of its kind to appear on the cover of the *Journal*. With this Thanksgiving motif we salute the Georgia physician who, we hope, doesn't have to "scrub up" on November 26.

The JOURNAL of the Medical Association of Georgia

MAKE YOUR RESERVATIONS FOR THE 1954 ANNUAL SESSION IN MACON MAY 2 - 5, 1954

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MANUSCRIPTS: Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE: Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

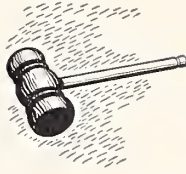
NEWS ITEMS: District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS: Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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MEDICAL EDITING SERVICE. If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISEMENTS: All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.



president's page

A County Society delegate to the Annual Session of the Medical Association of Georgia usually serves in the House of Delegates only one year before he is replaced by another well-qualified member of his Society. Unless the delegate has been fortunate enough to have been a member of the House of Delegates in previous years and to have become familiar with the functions of the House, his time is spent chiefly learning what is going on. Your County Society can be better represented and the functional capacity of the House of Delegates improved if two things are done.

First, a delegate should be elected from three to five years and, second, before his acceptance a delegate shall indicate his desire and willingness to attend *all* sessions of the House of Delegates.

Another problem of importance to County Societies has come to my attention. In certain parts of the state where the number of physicians is small, two or more societies get together for joint meetings. By doing this, better scientific programs can be arranged, and the social and professional contacts of the participating physicians are enhanced. There remain a number of counties where this type of organizational activity would be profitable. Prior to the scientific program, short meetings of the individual county societies can be held to transact necessary business including the election of a delegate.

In this busy over-organized country in which we live, your Association is making an effort to ask for a minimum amount of your valuable time. When called upon you can rest assured that your interest and participation is important to you and to organized medicine.

WILLIAM HARBIN



Tift County Hospital
Tifton, Georgia

The Tift County Hospital at Tifton, has recently been enlarged under the Hill-Burton Program. This enlargement included a completely new operating suite, renovated delivery rooms and suite, new central sterilizer and air-conditioning in the operating and delivery rooms. The heating and mechanical fa-

cilities were improved, old boilers and hot water tanks replaced. An emergency power unit was installed. A new kitchen and related food service facilities were provided. There were thirty new beds added, making the total capacity of the renovated hospital 63 beds.



Crisp County Hospital
Cordele, Georgia

The new Crisp County Hospital was opened at Cordele, in October, 1953. This hospital has forty beds with facilities for both white and Negro pa-

tients. The Adams Hospital in Cordele with a capacity of twenty-five beds will close shortly after the opening of the Crisp County Hospital.



physician's bookshelf

BOOKS RECEIVED

CLINICAL MANAGEMENT OF BEHAVIOR DISORDER IN CHILDREN: By Harry Bakwin, M.D., Professor of Clinical Pediatrics, New York University, Visiting Physician, Bellevue Hospital, and Attending Pediatrician, University Hospital, and Ruth Morris Bakwin, M.D., Associate Visiting Physician, Bellevue Hospital, and Director of Pediatrics, New York Infirmary. 458 pages. Published by W. B. Saunders Co., Philadelphia and London, 1953. Price \$10.00.

MODERN CLINICAL PSYCHIATRY: By Arthur P. Noyes, M.D., Superintendent, Norristown State Hospital, Norristown, Pennsylvania; Associate Professor of Psychiatry, Graduate School of Medicine, University of Pennsylvania. Fourth Edition 1953. 591 pages. Published by W. B. Saunders Co., Philadelphia and London. Price \$7.00.

THE ANATOMY AND SURGERY OF HER-NIA: By Leo M. Zimmerman, M.D., Professor of Surgery and Co-Chairman of the Department of Surgery, Chicago Medical School; Attending Surgeon, Michael Reese, Cook County and Chicago Memorial Hospitals, and Barry J. Anson, Ph.D. (Med. Sc.), Professor of Anatomy, Northwestern University Medical School; Member of Attending Staff, Passavant Memorial Hospital. 366 pages. Published by The Williams and Wilkins Company, Baltimore 2, Maryland. Price \$10.00.

FILMS IN PSYCHIATRY, PSYCHOLOGY & MENTAL HEALTH: By Adolf Nichtenhauser, M.D., Marie L. Coleman, and David S. Ruhe, M.D., Medical Audio Visual Institute of the Association of American Medical Colleges. 269 pages. Published by Health Education Council, Number 10 Downing Street, New York 14, New York, and Minneapolis, Minn. Price \$6.00.

CURE YOUR NERVES YOURSELF: By Louis E. Bisch, M.D., Ph.D., author of *Be Glad You're Neurotic, Your Inner Self, Clinical Psychology, and Why Be Shy?* 247 pages. Published by Wilfred Funk, Inc., 153 E. 24th Street, N. Y. 10. Price \$3.50.

REVIEW

HOLT PEDIATRICS: By L. Emmett Holt, Jr., and Rustin McIntosh. Twelfth Edition. Appleton-Century-Crofts, Inc.

This is the twelfth edition of this classic pediatrics text originally composed in 1896 by L. Emmett Holt, Sr. In time it has adopted the practice of using numerous contributing writers. Their views in the published form being synthesized with those of the authors', Holt and McIntosh. In this latest edition the "easy reading" style of earlier editions has been retained. A great improvement has been effected by the selection of heavier type.

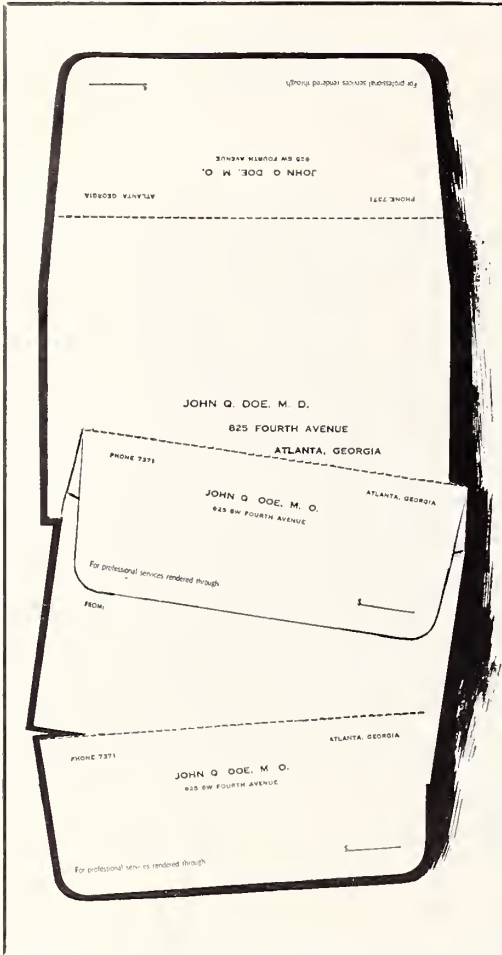
Continuing emphasis is placed upon growth and development including an excellent extensive section on nutrition. Approximately one-fifth of the entire

text is devoted to the consideration of the fundamental portions of the practice of pediatrics. The section on infectious diseases is particularly well written.

This text is not designed for the completeness of coverage of subject as Brennemann's *Practice of Pediatrics*, consequently, throughout the text one may sense that the individual writers have a suppressed desire to devote more space to differential diagnosis and medical management. This is particularly noted in regard to specific therapy. It is this brevity of discussion of treatment that limits the usefulness of the text in the care of the seriously ill patient.

Again, with the limitations in space in mind, the section on poisons is grossly inadequate for a pediatric text considering the frequency with which this situation presents itself.

Holt Pediatrics will be of especial interest to students and all practitioners caring for children for its classic descriptions of the infectious diseases and its excellent presentation of growth and development and nutrition.



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district and county societies

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Bullock-Candler-Evans—Deal, John Daniel, President, Portal; Deal, Albert, Secretary, Statesboro.
Burke—Butterfield, D. L., President, Waynesboro; Thompson, Cleveland, Jr., Secretary, Waynesboro. First Friday of each month.
Chatham—Morrison, H. J., President, Savannah; Osborne, Wm. W., Secretary, Savannah.
Emanuel—Brown, R. G., President, Swainsboro; Powell, C. E., Secretary, Swainsboro.
Jenkins—Lee, H. G., President, Millen; Mulkey, A. P., Secretary, Millen. First Friday of each month.
Montgomery—Kusnitz, Morris, President, Alamo; Palmer, J. W., Secretary, Ailey.
Screven—Hogsette, Gerald B., President, Sylvania; Freeman, James C., Secretary, Sylvania.
Tattnall—Hughes, J. M., President, Glennville; Pinkston, A. G., Jr., Secretary, Glennville. Second Wednesday, September and December.
Toombs—Finley, C. W., President, Vidalia; DeJarnette, R. H., Secretary, Vidalia.

SECOND DISTRICT

2ND DISTRICT—Roberson, Phil E., President, Albany; Little, Frank A., Secretary, Thomasville. Second Thursday—April and October.
Brooks—Jones, A. B., Jr., President, Quitman; Wasden, Harry A., Secretary, Quitman.
Colquitt—Brannen, C. N., President, Moultrie; Fike, R. H., Secretary, Moultrie.
Decatur-Seminole—DuPree, Thomas E., President, Bainbridge; Ehrlich, M. A., Secretary, Bainbridge. Second Tuesdays—March, June, September, December.
Dougherty—Dunn, Robert, President, Albany; Russell, Paul T., Secretary, Albany.
Grady—Rehberg, A. W., President, Cairo; Rogers, J. V., Secretary, Cairo.
Mitchell—Hackett, L. E., President, Camilla; McNeill, A. A., Jr., Secretary, Camilla.
Thomas—Little, Frank G., President, Thomasville; Wine, Mervin B., Secretary, Thomasville. Third Wednesday—every third month.
Tift—Zimmerman, Charles, President, Tifton; Bridges, W. L., Secretary, Tifton. First Tuesday each month.
Calhoun-Early-Miller—Rentz, T. W., President, Colquitt; Lamson, Thomas H., Secretary, Colquitt. Third Wednesday—Bimonthly.
Worth—Davis, H. G., President, Sylvester; Stoner, W. P., Secretary, Sylvester.

THIRD DISTRICT

3RD DISTRICT—Robinson, J. H., III, President, Americus; Gatewood, T. Schley, Secretary, Americus. Third Thursday—April and November.
Ben Hill—Williams, W. D., President, Fitzgerald; Roberts, Ralph D., Secretary, Fitzgerald.
Crisp—McArthur, C. E., President, Cordele; Gower, O. T., Jr., Secretary, Cordele.
Houston-Peach—Marshall, A. Smoak, President, Ft. Valley; Hendricks, A. G., Secretary, Perry.
Muscogee—Henderson, C. W., President, Columbus; Conger, A. B., Secretary, Columbus. Fourth Tuesday of each month.
Ocmulgee—Jones, Edward G., President, Eastman; Thomson, James L., Secretary, Eastman.

Randolph-Terrell—Ward, John A., President, Shellman; Martin, R. B., III, Secretary, Cuthbert. Second Friday of each month.

Sumter—Wilson, Frank A., III, President, Leslie; Fenn, Henry R., Secretary, Americus.

Taylor—Montgomery, R. C., II, President, Butler; Whatley, E. C., Secretary, Reynolds.

Wilcox—Harris, V. L., President, Rochelle; Owens, J. D., Secretary, Rochelle.

FOURTH DISTRICT

4TH DISTRICT—Kellum, J. M., President, Thomaston; Kinnard, George, Secretary, Newnan. Quarterly meetings.
Clayton-Fayette—Busey, T. J., President, Fayetteville; Sams, Helen F., Secretary, Newnan.
Henry—Ellis, H. C., President, McDonough; Foster, G. R., Jr., Secretary, McDonough.
Lamar—Crawford, J. B., President, Barnesville; Traylor, S. B., Secretary, Barnesville.
Meriwether-Harris—Chambless, Wm. G., President, Hamilton; Gilbert, R. B., Secretary, Greenville.
Newton—Paty, R. M., Jr., President, Covington; Palmer, Clarence B., Secretary, Covington.
Spalding—Oshlag, A. M., President, Griffin; Kelley, J. Welton, Secretary, Griffin. Third Tuesday of each month.
Troup—Mitchell, John T., President, LaGrange; Easley, Curran, Jr., Secretary, LaGrange.
Upson—Blackburn, John D., President; Thomaston; Gower, Wm. J., Jr., Secretary, Thomaston. First Tuesday each month.

FIFTH DISTRICT

5TH DISTRICT—Lange, Harry, President, Atlanta; Roberts, C. Purcell, Secretary, Atlanta. March and November.
DeKalb—Mendenhall, W. A., President, Chamblee; Leslie, John T., Secretary, Decatur. Second Monday—Sept., Oct., Nov., Dec., Jan.
Fulton—Hamm, Wm. G., President, Atlanta; Blalock, Tully T., Secretary, Atlanta. First Thursday—August, September, October, November, December, January.

SIXTH DISTRICT

6TH DISTRICT—Rawlings, Wm., President, Sandersville; Richardson, C. H., Jr., Secretary, Macon. Last Wednesday in June—First Wednesday in December.
Baldwin—Baugh, J. E., President, Milledgeville; Scott, Wilbur, Secretary, Milledgeville.
Bibb—Newton, Ralph, President, Macon; Tift, Henry H., Secretary, Macon. First Tuesday each month.
Hancock—Earl, H. L., President, Sparta; Tanner, David E., Secretary, Sparta.
Jasper—Belcher, F. S., President, Monticello; Lancaster, E. M., Secretary, Shady Dale.
Jefferson—Pilcher, George S., President, Louisville; Revell, Walter J., Secretary, Wadley. Second Thursday—Aug., Sept., Oct., Nov., and December.
Laurens—Anderson, R. T., President, Dublin; Kenney, Nell, Secretary, Dublin.
Monroe—Bramblett, A. Walker, Jr., President, Forsyth; Alexander, G. H., Secretary, Forsyth.
Washington—McElreath, F. T., President, Tennille; Helton, Wm. S., Secretary, Sandersville.

SEVENTH DISTRICT

7TH DISTRICT—Erwin, H. L., President, Dalton; Johnson, Ralph N., Secretary, Cartersville. No scheduled meetings.
Carroll-Douglas-Haralson—Denney, R. L., President, Carrollton; Reese, D. S., Secretary, Carrollton.

Chattooga—Allen, J. J., President, Trion; Martin, Wm. P., Secretary, Summerville. First Friday each month.
 Cobb—Burleigh, Bruce D., President, Marietta; Cauble, George C., Secretary, Marietta. First Monday—Sept., Oct., Nov., Dec. and Jan.
 Floyd—Dellinger, R. W., President, Rome; Smith, Stephen D., Secretary, Rome.
 Gordon—Steele, B. H., President, Fairmont; Richards, C. H., Secretary, Calhoun. Fourth Monday every other month.
 Polk—Chaudron, P. O., President, Cedartown; Spanjer, R. F., Secretary, Cedartown. Last Tuesday each month.
 Walker-Catoosa-Dade—Alsobrook, Thomas W., President, Rossville; Townsend, E. M., Secretary, Ringgold. Last Tuesday each month.
 Whitfield—Boozar, A. M., President, Dalton; King, Hubert U., Secretary, Dalton. Third Wednesday each month.

EIGHTH DISTRICT

8TH DISTRICT—Adkins, H. T., President, Waycross; Harper, Sage, Secretary, Douglas. Second Tuesday—April and October.
 Appling—Kennedy, R. F., President, Baxley; Brown, J. B., Jr., Secretary, Baxley. Second Tuesday of each month.
 Coffee—Jardine, Dan A., President, Douglas; Harper, Sage, Secretary, Douglas. First Thursday each month.
 Glynn—Towson, I. G., President, Sea Island; Hicks, J. N., Secretary, Brunswick.
 South Georgia—Austin, G. J., President, Valdosta; Perry, R. L., Secretary, Valdosta. Second Tuesday—Oct., Nov., Dec., Jan.
 Telfair—Mann, F. R., Jr., President, McRae; McRae, D. B., Secretary, McRae. First Monday each month.
 Ware—Knight, Arthur, Jr., President, Waycross; Ferrell, T. J., Secretary, Waycross. First Thursday each month.
 Wayne—Virusky, E. J., President, Jesup; Harper, Fred, Secretary, Jesup.

NINTH DISTRICT

9TH DISTRICT—Ward, E. L., President, Gainesville; Nicholson, George T., Secretary, Cornelia. April and September.
 Blue Ridge—May, L. E., President, Blue Ridge; Hicks, Thomas J., Secretary, McCaysville. Second Thursday of each month.

Cherokee-Pickens—Hendrix, Arthur, President, Canton; Nichols, Wm., Secretary, Canton.
 Forsyth—Bramblett, Rupert, President, Cumming; Mashburn, James S., Secretary, Cumming.
 Gwinnett—Kelley, D. C., President, Lawrenceville; Smith, R. E., Secretary, Buford.
 Habersham—Henry, C. M., President, Clarksville; Hicks, L. G., Jr., Secretary, Clarksville. First Thursday—each month.
 Hall—Gilbert, Ben, President, Gainesville; Smith, Martin Henry, Secretary, Gainesville. First Tuesday each month.
 Jackson Barrow—Rogers, A. A., President, Commerce; Moore, Lewis, W., Secretary, Winder.
 Rabun—Neville, Lester, President, Dillard; Dover, J. C., Secretary, Clayton.
 Stephens—Cleveland, P. B., President, Toccoa; Ayers, C. L., Secretary, Toccoa.

TENTH DISTRICT

10TH DISTRICT—Traylor, Bothwell, President, Athens; Schmidt, Donald W., Secretary, Lincolnton. Second Wednesday—February and August.
 Clarke-Madison-Oconee—Greene, James A., President, Athens; Elder, John D., Secretary, Winder.
 Elbert—O'Neil, J. B., III, President, Elberton; Mickel, C. A., Jr., Secretary, Elberton.
 Franklin—Brown, Stewart D., Jr., President, Royston; Poole, E. T., Secretary, Lavonia.
 Hart—Harper, George T., President, Dewy Rose; Cacchioli, Louis G., Secretary, Hartwell.
 McDuffie—Riley, B. F., Jr., President, Thomson; LeRoy, A. G., Secretary, Thomson. Third Thursday each month.
 Morgan—Dickens, C. H., President, Madison; McGeary, W. C., Secretary, Madison.
 Richmond—Philpot, W. K., President, Augusta; Mulherin, J. L., Secretary, Augusta. Third Thursday—Sept., Oct., Nov., Dec. and Jan.
 Walton—DeFreese, S. J., President, Monroe; Thompson, Ernest, Secretary, Monroe. Second Monday of each month.
 Warren—Cason, H. B., President, Warrenton; Davis, A. W., Secretary, Warrenton.
 Wilkes—Wills, C. E., Jr., President, Washington; Adair, M. C., Secretary, Washington.

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MECHANICAL PSYCHIATRY

WE as physicians have a grave responsibility to those patients who become emotionally disturbed and to their families. The choice of a psychiatrist with good training and judgment is just as important as the selection of a good surgeon. Families of patients are helpless and are willing to go to great lengths to wrest their loved ones from a mental illness. We must not allow these patients to fall into the hands of incompetent or unscrupulous individuals.

Some so-called psychiatrists seem to have forgotten that electric shock therapy is a tool for establishing contact with a patient so that psychotherapy may be instituted. After a ten to fifteen minute inter-

view they prescribe and administer shock with little or no follow-up psychotherapy. The patient, as a consequence, loses his will to fight and turns to shock therapy whenever the going becomes rough.

In one case, a psychiatrist administered electric shock to a patient on the basis of a single brief interview. It later developed that the wife of the patient, who brought her husband to the psychiatrist, was a clever paranoid schizophrenic. Weeks of careful observation of a patient and consultation with other members of the family may be required to determine the proper management of such a situation.

Most psychiatrists are careful, conservative men. To the minority who are not, we must show our displeasure by refusing to entrust patients to them.

TURNABOUT

is

FAIR PLAY

ADVERTISERS in the *Journal of The Medical Association of Georgia* can expect preferential treatment from the physicians of Georgia who use their services or products. And rightly so—for when the *Journal* carries a firm's advertisement, the physician realizes that the service or product advertised is reputable and backed by an ethical house. This can be taken for granted as all advertising matter run in the *Journal* has been investigated and approved by the Editorial Board of the *Journal*. The physician is also aware of the fact that the advertiser, while receiving benefit from the display of his product or service, is supporting and making financially possible the publication of the state medical journal. These two factors play a great part in the physician's choice of products as he uses them in daily practice.

Yet the physician may also wonder why certain products are not advertised regularly in the *Journal*. There are many large firms selling a considerable volume of products to the physicians of Georgia who do not advertise in the state medical journal. And these same firms enjoy a prosperous relationship

with the doctors of the state. Certainly it would further benefit these firms to advertise. And their advertisement would benefit your *Journal*.

To expedite this project, the individual physician can ask each firm representative "do you advertise in our *Journal*." By so doing, the various trade houses will ultimately realize the advantages of advertising in the Georgia medical journal. If each physician supports the firms that support our *Journal*—and encourages the non-advertisers to support our *Journal*—your *Journal* can continue to be a leader in the field.

If the physicians of Georgia will cooperate and bring this subtle "pressure" to the attention of trade house representatives not advertising in the *Journal*, the situation will correct itself. And as the *Journal* increases its advertising, a better publication can be envisioned. Your cooperation is urged—for a better state medical journal will better Georgia medicine.

DID YOU KNOW?

There were 128 maternal deaths in 1952. Of the 128, 48 died of hemorrhage as reported to you last month, and 45 died of Toxemia. Toxemia of pregnancy caused 45 expectant mothers to die.

Could these 45 deaths have been prevented?

Prenatal care is given primarily to determine signs and symptoms of Toxemia. Did these women have adequate prenatal care? Were they properly schooled in signs and symptoms of Toxemia and then fail to seek medical advice when signs and symptoms occurred? Were the signs and symptoms recognized,

medical advice obtained but facilities found to be inadequate for treatment? Was the accepted plan of therapy administered?

Forty-five pregnant women in 1952 have died of Toxemia with the physicians, trained midwives and hospitals available in our state. This number should be reduced.

This is your problem, Doctor. What can you do to reduce the number of maternal deaths in our state, especially to reduce the number—45—who died of Toxemia?

MAG Maternal Welfare Committee

INVESTMENT

Most of us are so busy with our professional affairs that we are not always able to devote adequate time and thought to the investing of surplus funds. There are so many angles to consider—safety, yield, tax situation, diversification, supervision of investments, family and retirement needs, etc.

Investing money where it will do the most good for a doctor's own particular needs and circumstances always poses certain questions. But when it is being set aside to help carry us along in later years, other considerations of a rather special nature enter the picture. We have such questions as: How much income will I be guaranteed under the various investments I may have accumulated? What about taxes? At what age do I wish to retire? How much income do I want? etc.

An idea has come to our attention which we feel will be of interest to doctors in helping them to meet some of the above questions. It enables a doctor to take the investments which he has accumulated over the years and, when he wants to ease up or fully retire, convert these investments into a guaranteed life income. And the basis of making this conversion then is guaranteed now, for those years out in the future. The plan also possesses flexibility in that if circumstances at retirement indicate that it isn't desirable to use investments for pension purposes, one is not committed to follow through on the conversion. We have often heard the expression, "Have your cake and eat it too," and that is what this unique arrangement enables one to do.

of Surplus Funds

As we understand it, the plan fits the needs of the professional man in several ways. At retirement he knows that he can convert part of his investments which he may have in stocks, bonds, real estate, etc. into annuity income with its many benefits such as guaranteed income, favorable tax treatment and the high yield which is possible under an annuity arrangement.

In addition there are tax advantages which deserve consideration.

Any doctor who embarks on one of these programs is also doing something which, in the future, may be of more value than is apparent at the present time. That is the provision in the plan which protects him against any possible increase in annuity rates, although it may be years before he will want the annuity payments to begin.

It is apparent to all of us that people are now living longer. If this trend increases, and if past experience is any indication, annuity rates may be increased to guarantee the longer period of income which is necessary.

The plan is based upon a combination of a life insurance contract and other investments which a doctor may have, or hopes to have in the future. Many of us may find that this idea is something which we will want to investigate further.

ENDOMETRIOSIS:

A Problem For the Patient and the Doctor

JOHN H. RIDLEY, M. D., Atlanta

The enigma of the cause, origin or behavior of endometriosis continues to plague the gynecologist, obstetrician and endocrinologist. The clinical incidence of the disease is increasing, and even though the medical profession is more aware of its presence, the disease presents diagnostic and therapeutic problems that are remarkable challenges to even the most experienced.

Endometriosis is defined simply as an ectopic location of endometrium. It may be of an internal type or adenomyosis, or it may be of an external type with its location elsewhere than in the myometrium. These terms are confusing because they give one the impression that an external type may occur on the surface of the body. This is, indeed, rare.

Historically, it is a "young" disease. The first plausible explanation of its occurrence was as late as 1921 by Sampson. However, Russell⁸ described, in 1899, microscopic "Mullerian rests in the ovary," which in retrospect is known to have been endometriosis. Cullen described adenomyosis and demonstrated its origin in 1908 in his book on "Adenomyosis." Although the explanation for the origin of extrauterine endometriosis is even today disputed, no one has ever more conclusively demonstrated the origin of adenomyosis than did Cullen in his study by serial sections of the uterus in 1908.

Since Sampson in 1921⁹ introduced his theory of origin by retrograde regurgitation of menstruum, (Fig. 1), it has been conclusively shown that Sampson's theory could not possibly apply to explain all the sites of occurrence of ectopic endometrium. For instance, we see endometriosis of the umbilicus and in regional lymph glands where "regurgitated" cells, if viable, could not logically implant.

Consequently other plausible, but not all-inclusive, theories of the origin of endometriosis have been proposed. Among these, including the two mentioned above, the following are the most logical and widely accepted:

Read before the Georgia Medical Society in Savannah, January 13, 1953.

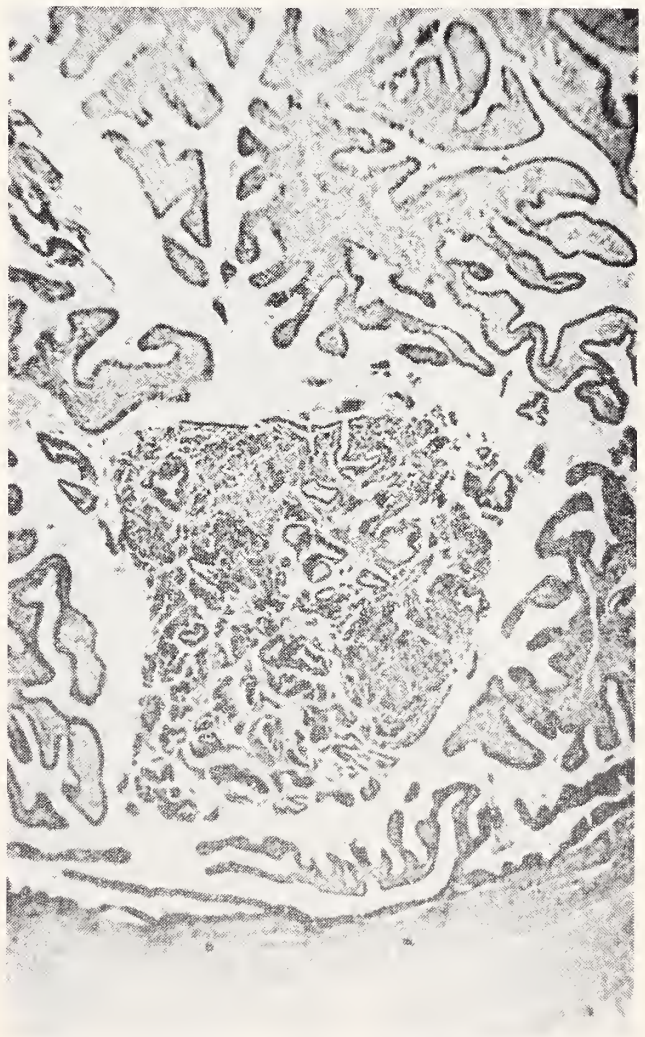


Fig. 1. Large viable fragment of endometrium found within lumen of ampulla of Fallopian tube. *Am J. Obst. and Gyn.*, Sept. 1951.

A. Theory of Mullerian cell rests of ovary; Russell 1899.⁸

B. Theory of Regurgitated cells with abdominal implantation; Sampson 1921.⁹

C. Theory of celomic metaplasia: This is a premise that endometrial rests occur in various areas of the pelvic peritoneum by metaplasia or abnormal

differentiation in germinal epithelium. The areas supposedly are derived from the celomic epithelium. Here again, this theory, championed by many of the world's best known gynecologic pathologists and gynecologists such as the late Dr. Robert Meyer⁶ and Iwanoff³ and more recently Emil Novak,⁷ fails to explain all instances of endometriosis. It is well known that endometrial implants can thrive at locations far removed from the original celom.

D. The theory of Halban² of lymphatic dissemination: Recently more credence has been given to this theory by Javert⁴ who has shown conclusively microscopically that endometrial fragments, both glands and stroma can be transported by lymph vessels and grow in regional lymph glands (Fig. 2). Many practicing gynecologists have found endometriosis of the inguinal chain. This plausible explanation of certain types of implants does not explain all cases, however.

In substantiation of these above named theories, many workers have done extensive work. In support of Sampson's theory of regurgitation into the abdominal cavity, TeLinde and Scott¹⁰ have offered strong evidence by ingenious surgery on the Rhesus monkey that endometrial cells in the menstruum are viable and can grow not only with the peritoneal cavity but in extracelomic areas (Fig. 3). However, this has never been demonstrated in the human. An effort is currently being made at the Grady Memorial Hospital in Atlanta, to demonstrate that these "exfoliated cells" or cast off cells in the menstruum are not only viable but may thrive in locations away from the celom. Success or failure of this effort will be subsequently reported.



Fig. 2. Cross section of inguinal lymph gland with endometriosis (inset.) Am. J. Obst. and Gyn. Sept. 1951.

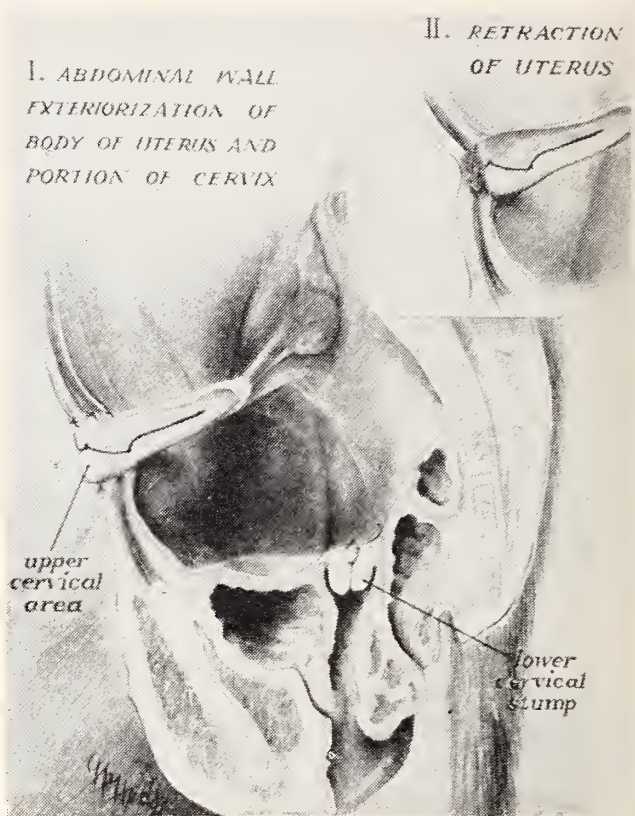


Fig. 3. I. Cross section of monkey pelvis with surgically displaced and exteriorized cervix. II. (Inset) reveals area where endometriosis was found in abdominal scar overlying lower end of endocervical canal. Am J. Obst. and Gyn. Nov. 1950.

In support of theory "C," that of celomic metaplasia, are such facts as reported cases of endometriosis occurring at sites of foreign body irritation. These cases have been observed following the transuterine injection of radiopaque iodized oil.¹ It is also suggested that endometriosis of the upper arm and thighs occur in celomic cell rests that are carried into the extremities by budding from the original celom.

Halban observed an occasional lymph gland containing typical glands and stroma of the endometrium. He concluded that a benign metastasis of these cells took place via the lymph channels. This has been conclusively proven, by Javert. He has found not only numerous cases reported of endometrial adenosis, but has actually demonstrated microscopically, lymph vessels filled with viable endometrium.

Endometriosis is a problem to the patient chiefly because of the high incidence of sterility and pelvic pain. Just what causes the sterility is not clear. It is theorized that periovarian and peritubal adhesions may interfere with ovum migration or even with ovulation. The gynecologist sees the occasional childless patient with patent Fallopian tubes, evidence of ovulation, and an otherwise normal pelvis, except for the existence of endometriosis which is sometimes early and asymptomatic.

The amount of pain the patient may experience is by no means proportionate to the extent of endometriosis. Occasionally it is found that a patient has

nearly a "frozen pelvis" with endometriosis, in the absence of discomfort. Another woman may be so exquisitely tender on pelvic examination and with such pronounced dysmenorrhea that she is truly a "pelvic cripple." She may also have the least extensive degree of endometriosis.

Endometriosis is chiefly a problem for the doctor because he knows no prophylaxis. Meigs⁵ advocates early motherhood. It is further a problem because of the difficulty of control and cure of the disease. The gynecologist is constantly beset by the difficult decision he must make in balancing conservative measures against control and cure. It would be easy to castrate the patient, but this is rarely considered, primarily because this disease is one predominantly of the young woman in the prime of the childbearing era. It would frequently be simpler surgically to perform a pelvic cleanout, but this is rarely considered because the gynecologist wants to reestablish, if possible, the ability to bear children or at least to preserve some ovarian tissue in order to avoid the storm of an early surgical menopause.

Therefore, the gynecologist meets his true test as a gross pathologist in deciding whether endometriosis is actually present or not, and how extensive the process is. The existence of the small brownish purple blebs usually 1 to 2 mm. in diameter, surrounded by stellate scarring and adhesions is pathognomonic of the disease. The existence of the textbook picture of the "chocolate cyst" of the ovary is highly suggestive but not conclusive because of other conditions in which an ovarian cyst, filled with old blood, may be found. At times the gross differentiation between endometriosis and a malignancy may be practically impossible. In such cases, particularly in those in which the adjacent colon is involved, the operator must resort to a frozen section before a final decision of disposition can be made.

It has been proven statistically that endometriosis is increasing; not only is it being suspected more

often, but actually has been proven to exist in more suspected cases than ever before. Surveys of the statistics of various large clinics including the Johns Hopkins Hospital, the Massachusetts General Hospital, the Free Hospital for Women in Boston, and the Cleveland Clinic have shown that we undoubtedly are encountering more previously undiagnosed and unsuspected endometriosis. These facts are borne out by observers in private practice who report pelvic endometriosis in 18 to 25 per cent of laparotomies performed, with many being done primarily for other reasons. Our own findings parallel the lesser percentage.

Not only is the medical profession becoming more conscious of the disease but the lay public as well is becoming educated by the doctors themselves and by lay magazine articles.

This unusual disease is, then, a major problem for both the doctor and his patient. It strikes in the upper strata of society and has been facetiously (but with some truth) named the disease of intelligence and prosperity. But, truly, we doctors are confused by its origin, and are troubled by the problems of its control and cure.

1211 West Peachtree St., N.E.

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Better Health Council Formed in Rome

A local Better Health Council of Georgia was organized in Rome, Georgia, the evening of October 20, 1953. This organizational meeting was the result of the efforts of the members of the Health and Safety Committee of the Business and Professional Woman's Club in Rome. Several weeks of planning and two preliminary meetings brought together a cross-section of approximately 30 local organizations who voted unanimously to formulate a local health council and elected as temporary chairman, Mr. Gra-

ham Thomas, a member of the Chamber of Commerce of Rome.

Among those present was Dr. William Harbin, President of the Medical Association of Georgia, who gave the whole hearted endorsement of the Medical Association to the Council group.

Mrs. Shelley C. Davis was the speaker of the evening and presented *Georgia Facts* on the health needs of many pertinent problems.

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CONTROL STUDY

of Combinations of Synthetic and Antibiotic DRUGS

in the Treatment of PULMONARY
TUBERCULOSIS

H. E. CROWE, M.D., Rome

RUFUS F. PAYNE, M.D., Augusta

Even before the introduction of "specific" drug therapy in the treatment of pulmonary tuberculosis it was realized that many problems would be encountered, due to the nature of the disease, that would make the evaluation of any therapeutic agent difficult. Pinner¹ implied that a control study would be necessary for proper evaluation of such agents. More recently McDermott² has pointed out the many factors which would influence the results of antibiotic or chemotherapy in pulmonary tuberculosis and suggested that military tuberculosis offered a better field for such evaluation. The limitations and difficulties of such a study on a large scale are perfectly apparent. This coupled with the probability that results in military tuberculosis could not be used to assess the value in pulmonary tuberculosis, and make a control study the logical method of choice in determining which agent or combinations of agents will be found most effective in the treatment of pulmonary tuberculosis.

The usefulness of this method has been demonstrated by previous studies³ in which Streptomycin and para-amino-salicylic acid were compared with Streptomycin alone by a group of investigators using a common protocol with patients for the different regimens being assigned on a random basis by a central coordinating agency. The Veteran's Administration has also developed a slightly modified method whereby a group of hospitals under central control can use such methods for testing new and/or old drugs in various combinations and dosages.

With the introduction of a new synthetic agent, isoniazid, a study was initiated by the Division of Chronic Diseases and Tuberculosis of the United States Public Health Service in cooperation with twenty-two tuberculosis hospitals in the United States

for a planned investigation of the merits of this agent alone and in combination with streptomycin as compared with streptomycin and para-amino-salicylic acid. The methods of study and preliminary results⁴ are available for these combinations.

At the time this study was started a decision was made to test the merits of other combinations⁵ of these three drugs on a "pilot" basis to indicate whether further investigation was warranted. Battey State Hospital was selected for this purpose since it would furnish larger numbers of patients than any other hospital, and since the cases for these pilot studies could be selected at random from a more homogenous group than if they were selected from all of the participating hospitals. A report⁵ has already been made as to the different pilot regimens to be employed in addition to the three described above.

The purpose of the present report is to detail briefly the methods used in evaluating cases and to present the suggestive but inconclusive results of this investigation at forty weeks after start of treatment.

The present report deals only with those cases who were presumably sensitive to streptomycin at the start of treatment since they had been given no previous chemotherapy and who continued treatment in the hospital unless death or drug reaction prevented. There were a total of 150 cases. Three died, leaving 147 to complete the 40 weeks of treatment.

One patient died of coronary occlusion two months after treatment was started and no film is available for comparison. One patient died in less than one week after treatment was started and no film is available for comparison. The third patient can be considered a failure for Regimen VIII

The authors wish to express their appreciation to Drs. Fred Crenshaw, Frank Blalock, and Walter H. Ketchum, Battey State Hospital for their participation in this study.

(isoniazid twice weekly and streptomycin twice weekly) since he died of pulmonary tuberculosis approximately six months after treatment was started. No forty week film is available for comparison but a film at 20 weeks showed that the disease, which was present in all lobes, had become more extensive and that cavitation, present in three of the six designated lung areas, had increased markedly.

There have been no patients, in this group, who developed drug intolerance to isoniazid to the point where it had to be stopped.

Complete objectivity in assignment of drug therapy was maintained by strict adherence to the policy of central office randomization to the following therapeutic regimens: Regimen I- streptomycin twice weekly (1 Gm.) and PAS daily (10 Gm.); Regimen II- streptomycin twice weekly (1 Gm) and isoniazid daily (3 Mg/K); Regimen III- isoniazid daily (3 Mg/K; Regimen IV- isoniazid daily (3 Mg/K) and PAS daily (10 Gm.); Regimen V- combination of all three drugs, same dosage and interval as above. Regimen VI- isoniazid twice weekly and PAS daily in dosages as above. Regimen VII- INAH twice weekly, streptomycin twice weekly and PAS daily. Regimen VIII- isoniazid twice weekly and streptomycin twice weekly.

It was decided early in the study that the ordinary methods of describing or evaluating the total disease picture at any point in the study were not as precise as would be desirable. It is recognized that age, sex, race, infecting dose, virulence, etc.⁵ all have an important role in determining the fate of a tuberculous infection, but we doubt that these factors are of as much value in predicting the fate of a given lesion as would be the lesion itself. In other words the lesion is much more likely to be the end result of these factors and, properly assessed, will be of more value in clinical evaluation of the case than these other factors.

In an effort to properly evaluate each case at the start of treatment a panel of the chiefs of each service at Battey made an interpretation of the X-ray film at the start of treatment and agreed upon one common classification of the lesion. This method of classification is subject to the criticism that X-ray interpretation can not always define the precise pathological condition, even though the reader be an expert. This is true without question, and is completely without significance if the same type of lesion presents the same X-ray appearance each time and if the X-ray reader remains constant in his classification. The method of classification finally adopted could be improved considerably but was adopted in an effort to find out what happens to lesions under these various regimens of drug treatment rather than to try to prove the superiority of any particular form of therapy.

Method of Classifying Lesions

Each film was classified as to the predominant type of lesion which was present. It was found that practically all cases could be listed under three types,

namely, exudative, mixed and fibrocaseous. The first two were non-cavitary and the latter was always cavitary. The distribution of these types of cases between the different regimens is shown below.

TABLE I

Distribution of cases by predominant type lesion.
Percentage of total cases

Regimen	Total Cases	Exudative	Mixed	Fibrocaseous
I	12	8	50	42
II	18	17	28	55
III	24	12	29	59
IV	22	27	36	37
V	23	9	39	52
VI	16	25	19	56
VII	16	12	44	44
VIII	16	12	32	56
	147			

If we assume that cases can be classified in such a manner that the type lesion will determine, within reasonable limits, the outcome of the disease it ought to be a useful method to differentiate cases to determine if drugs or their combinations have the same effect on different type lesions. If they do have different effects or if there is a real difference in response when one or another type of disease predominates this would also be a useful method of studying small groups of cases of different types for drug response.

The only test which we can use, other than clinical experience, to assure us that the above rather arbitrary methods of selection do give us different types of cases is to check the number or proportion of each group who showed positive bacteriology.

TABLE II

Cases showing positive culture on one pooled specimen of sputum in relation to predominant type lesion

Type of Lesion	Cases	Positive Culture
Exudative	23	55 Per Cent
Mixed	50	68 Per Cent
Fibrocaseous	74	91 Per Cent

If treatment results are determined by X-ray clearing and bacteriological response the following table shows the results for all types of cases.

TABLE III

X-ray and bacteriological results of treatment with different combinations of streptomycin, isoniazid and PAS at 40 weeks as expressed in per cent of total cases by regimen.

Regimen	Cases	Marked	Slight	No change	Worse	Cult Rev
I	12	42	17	33	8	90
II	18	44	17	39	0	100
III	24	17	42	33	8	42
IV	22	32	41	18	9	94
V	23	22	39	39	0	88
VI	16	55	37	8	0	91
VII	16	25	50	25	0	100
VIII	16	25	50	25	0	67
	147	31	38	28	3	84

While the number of cases is limited this table would indicate that isoniazid alone is a decidedly inferior drug to any other combination used in this study. One can not be certain that it adds very much to the effectiveness of streptomycin although it can be said that there were no positive cultures at forty weeks in the group treated with both drugs. Isoniazid twice weekly and PAS daily showed more cases with marked X-ray clearing than any other group, while isoniazid daily and PAS daily was apparently less effective.

When results of treatment were correlated with the predominant type lesion the following tables show the results in the various regimens.

TABLE IV

Results of treatment in predominantly exudative type lesions as expressed in per cent of total cases by regimens

X-RAY CHANGES					
Improvement					
Regimen	Marked	Slight	No change	Worse	Cul Rev
I	0	0	100	0	None
II	67	33	0	0	100
III	33	67	0	0	100
IV	17	66	0	17	100
V	50	0	50	0	100
VI	75	25	0	0	100
VII	0	50	50	0	100
VIII	50	50	0	0	100
	39	43	13	5	100

TABLE V

Results of treatment in predominantly mixed type lesions as expressed in per cent of total cases by regimens.

X-RAY CHANGES					
Improvement					
Regimen	Marked	Slight	No change	Worse	Cul Rev
I	50	17	33	0	100
II	20	0	80	0	100
III	0	57	43	0	80
IV	38	24	38	0	90
V	11	45	44	0	100
VI	0	100	0	0	66
VII	14	72	14	0	100
VIII	20	40	40	0	100
	20	42	38	0	92

TABLE VI

Results in predominantly fibrocaceous type lesions as expressed in per cent of total cases by regimens.

X-RAY CHANGES					
Improvement					
Regimen	Marked	Slight	No change	Worse	Cul Rev
I	40	20	20	20	80
II	50	20	30	0	100
III	21	27	38	14	33
IV	38	38	12	12	100
V	25	42	33	0	78
VI	67	22	11	0	100
VII	43	29	28	0	100
VIII	22	56	22	0	50
	37	34	26	3	

A review of three tables above suggests that chemotherapy either has more effect in fibrocaceous dis-

ease than we had formerly suspected or that the clinician is more likely to be impressed by a small amount of cavity resolution than he is with the same resolution of mixed and exudative lesions.

The bacteriological response is certainly greater, although the number of cases is smaller with exudative than with mixed or fibrocaceous lesions.

The number of cases is entirely too small to be certain that any one regimen is superior to another except to say that by all methods of measurement used, Regimen III (isoniazid alone) certainly appears inferior to all others and that isoniazid and PAS appear to be equal or superior to streptomycin and PAS except in the mixed or predominantly hard type of lesion.

Since an X-ray represents visible shadows of disease in many different areas and there may be a different type of disease in each area, an attempt was made to classify the disease found in different areas. The X-ray film was arbitrarily broken into six segments (not anatomical) and each area was considered separately. These were called right upper, right middle and right lower; left upper, left middle and left lower. Since a smaller area was involved it was thought that the predominant lesion in each area might be more precisely described. This method assumes that either the type lesion having the greatest volumetric measurement will be classified as the type disease present or that certain types of lesions will take precedence over other types regardless of the volumetric comparison of the two. We used a combination in which the volumetric measurement is the determining factor unless a cavity be present. In other words the right upper area may show a mixture of disease in which cavity, newly developing soft confluent spread, and, an older area of resolving and predominantly modular or stringy type fibrosis is present. This area would be classified as cavitory disease and as being under or over four cm in size and as having or not having a definite fluid level. On the other hand if a cavity was not present this area would be classified either as a predominantly soft or as a predominantly hard mixed type of lesion. The final classification of these segments allowed for many different types but when they were tabulated it was found that the following table showed the great bulk of all the different types classified.

TABLE VII

Distribution of segmental disease
Percentage of segments showing

					Cavities	
Regimen	Total Segments	No Disease	Mixed Productive	Mixed Exudative	Under 4	Over 4
I	72	43	22	26	3	6
II	108	39	23	25	8	5
III	144	43	26	17	8	5
IV	132	40	31	21	2	5
V	138	42	28	17	9	4
VI	96	43	18	22	8	9
VII	96	51	19	18	8	4
VIII	96	46	19	22	5	8
	882	43	24	21	7	6

Results of therapy were determined by a study of the X-rays made at forty weeks and from the bacteriological response. The original X-ray was compared with the one made at forty weeks and the amount of clearing was graded on a percentage basis. The appearance of new disease, the extension of old disease or the enlargement of cavities were the specific factors responsible in determining worsening.

Results in Segments Showing No Disease Originally

There were 380 segments which showed no disease in the original films and at forty weeks there were no segments which showed new disease in spite of the fact that some of these cases continued to show positive smears and cultures. In view of the well known tendency of tuberculosis to spread into new areas it is assumed that chemotherapy is responsible for the failure of the disease to progress into previously uninvolved areas. Since there were no new spreads in any of the regimens it is obvious that no choice can be made between the different regimens as to which is most effective.

TABLE VIII

Results in segments which originally showed a predominantly productive type of lesion, percentage of segments showing.

Regimen	Segments	Resolution				Worse
		No Change	50-100%	25-50%	0-25%	
I	16	82	12	0	0	6
II	25	68	8	4	20	0
III	38	76	5	5	10	4
IV	41	59	27	0	15	0
V	38	61	0	8	31	0
VI	17	35	29	0	35	0
VII	18	56	0	16	28	0
VIII	18	56	6	0	39	0
	211	63	11	4	21	1

Strict objectivity was maintained in the interpretation of X-rays by using the same panel who made the original reading and who were not familiar with the cases and had no knowledge of the assigned regimen. Since there were no cavities in this group resolution is based on volumetric change in the infiltrate. For most cases it can be stated that 50-100 per cent resolution refers to almost complete clearing of the lesion. There are still many unanswered questions about this type of lesion and its response to antibiotic and synthetic agents but in general it would appear that further trial of isoniazid and PAS is indicated since there is no evidence from these results that streptomycin adds anything to the effectiveness of these other two agents. Bacteriological response can not be properly evaluated in this type of study since there may be other segments with cavities which continue to harbor tubercle bacilli but it was noted that these cases showing no cavitary disease demonstrated more than 90 per cent reversal in sputum cultures with only regimens III, IV and VI failing to convert all positive cultures and each of these regimens had only one failure.

TABLE IX

Results in segments which originally showed a predominantly exudative type of lesion, percentage of segments showing

Regimen	Segments	Resolution				
		No Change	50-100%	25-50%	0-25%	Worse
I	19	42	31	15	6	6
II	27	30	44	0	26	0
III	25	48	28	0	18	8
IV	28	18	39	11	25	7
V	23	35	39	22	4	0
VI	21	19	48	14	19	0
VII	17	29	47	0	24	0
VIII	21	48	19	10	19	4
	181	33	37	9	18	3

The six segments which showed worsening were mostly segments in which a cavity was seen on the forty weeks film and in view of the number of soft confluent patches of lobular pneumonia (there were three typical lobar pneumonias in this group also) it would appear that many more cavities would have developed had not the drugs exerted an inhibiting effect. When compared with the previous table which showed the effects in the more productive type lesion it is noted that these lesions show much more beneficial response to therapy. While bacteriological response can not be determined from this table it was noted that all patients whose lesions were classed as primarily exudative showed a reversal of all positive cultures to negative. As to choice of regimens for this type of disease it would appear again that a combination of isoniazid and PAS ought to have further investigation. As with the more productive type of mixed lesion there is no indication that this combination is inferior to streptomycin and PAS but actually that a higher proportion of segments show a more complete resolution under this type of therapy.

TABLE X

Results in segments which originally showed either soft or productive mixed lesions without cavitation—Percentage of total segments showing.

X-RAY CHANGES

Regimen	Segments	Improvement				
		No Change	50-100%	25-50%	0-25%	Worse
I	35	60	23	9	3	5
II	52	48	27	2	23	0
III	63	65	14	3	13	5
IV	69	42	32	4	19	3
V	61	51	15	13	21	0
VI	38	26	40	8	26	0
VII	35	43	23	9	25	0
VIII	39	51	13	5	28	2
	392	49	23	6	20	2

If this method of assessing the value of drugs be considered even fairly reliable it would appear that non-cavitary disease is most likely to show the greatest response, in terms of maximum resolution, under

combined isoniazid and PAS. In terms of no change in X-ray resolution, or worsening, regimen VI (isoniazid twice weekly and PAS daily) had fewer segments than any other group. In terms of what not to use for this type of disease it would appear that Regimen III (isoniazid alone) gives the poorest results of all the Regimens while Regimen VIII (isoniazid and streptomycin each twice weekly) and Regimen I (streptomycin and PAS) are next in line. While the bacteriological results can not be given for this group of segments it was noted that those cases which showed no cavitory disease had a reversal of sputum in 93 per cent of the cases that were originally positive.

TABLE XI
Results in segments which originally showed the presence of cavities. Percentage of total segments showing.

Regimen	Segments	Resolution				Worse
		No Change	50-100%	25-50%	0-25%	
I	6	33	33	0	33	0
II	14	36	57	0	7	0
III	19	69	10	0	21	0
IV	10	10	60	10	20	0
V	19	31	21	10	37	0
VI	17	6	65	6	23	0
VII	12	42	25	25	8	0
VIII	13	15	23	38	23	0
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	110	32	35	11	22	0

The same criteria were applied for reading films for the cavitory segments as for the non-cavitory segments except that the amount of resolution was much more likely to apply to the cavity rather than the surrounding disease. It was noted that there was practically no instance in which the clearing of infiltration did not equal or exceed the clearing (reduction in size) of the cavity itself. There were also one or two instances in which the cavity did not change but the infiltrative disease cleared almost completely but in most cases there appeared to be more or less equal resolution of different parts of the lesion.

It was somewhat surprising to note that the cavitory disease cleared about as rapidly and completely as did the soft types of infiltrative disease. Since the number of involved segments was smaller than for the other types of disease one can not be as certain that a larger number of segments would show the same results but apparently the combination of isoniazid and streptomycin (Regimen II) seems to exert its greatest effect on this type of lesion, as compared with its effect on lesions shown in Tables VIII, IX and X, although the combination of all three drugs (Regimens V and VII) did not seem to show any indication of superiority. An attempt was made to compare results in cavities under four cm in size as against those more than four cm but the number of segments was so small that no conclusions were possible but it was noted that isoniazid and PAS (Regimens IV and VI) seemed to show the same effectiveness regardless of size of cavity.

Bacteriological results are obviously of no value unless there is reversal of sputum by culture in all

cases in which a cavity was present originally. It was noted that this occurred in Regimen II (streptomycin and isoniazid), Regimens IV and VI (isoniazid and PAS) and Regimen VII (all three drugs). It was noted in Regimen I (streptomycin and PJAS) that positive smears and negative cultures were obtained on some cases but this did not occur in any other regimen. Isoniazid alone (Regimen III) had the greatest number of bacteriological failures in cavitory disease as well as the largest number of segments which showed no X-ray clearing.

No data is available that would give us any clue as to the emergence of drug resistant organisms in this group of patients because the number of patients at 40 weeks with positive cultures is limited to 21 of which eight are in Regimen III (isoniazid alone) with at least one in each of the other regimens except VII, and with two of the regimens have two each. It is most unfortunate that the regimens having isoniazid and PAS only had one each so that no data is available from any source for patients with streptomycin sensitive organisms who were treated for as long as forty weeks with isoniazid and PAS. However other data is soon to be published from the patients in all the hospitals who are on the first three regimens. Briefly, this data was collected at 28 weeks and shows the following: when the patient was given isoniazid alone practically all the positive cultures at 28 weeks showed some degree of resistance to the drug; when both streptomycin and isoniazid were given in combination practically all cultures positive at 28 weeks showed resistance in some degree to both drugs; when streptomycin and PAS were given all cultures positive at 28 weeks were at least moderately resistant to streptomycin. It was noted that organisms became resistant very early in treatment to isoniazid but that there was remarkably little evidence of worsening as denoted by changes in X-rays.

Summary

An original group of 150 patients never previously having had chemotherapy and treated for forty weeks, or until death, in a controlled study is reported. Patients were assigned by methods of random selection to eight different regimens in which either isoniazid alone, streptomycin and PAS or isoniazid in combination with either one or both of the other two drugs was used.

A method of X-ray classification of lesion is presented whereby the effect of drug therapy on different types of lesions may be studied.

This study suggests that any one of the drug Regimens employed is effective in preventing the spread of disease into previously uninvolved parts of the lung; that areas having a predominantly productive type of lesion show the least amount of X-ray clearing in terms of complete resolution and that there is no great difference in the amount of maximum resolution shown by exudative types of lesions and cavitory type disease; that isoniazid alone is definitely inferior to the other regimens employed both in the amount of maximum X-ray clearing and also in bacteriological response; that a combination of isoniazid twice weekly and streptomycin twice weekly also

appears to be inferior to all regimens except isoniazid alone; that the addition of isoniazid to streptomycin increases the amount of maximum X-ray clearing that can be obtained with streptomycin alone except possibly in predominantly productive non-cavitary lesions; that there are very few cases of disease areas becoming worse in any regimen; that a combination of isoniazid and PAS appears to be the most effective for all types of lesions and it apparently makes no difference whether isoniazid is given daily or twice weekly, although the latter dose was slightly better in all types of lesions; that no decision can be reached at this time concerning the development of drug resistance and its significance clinically.

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Correlation of

RADIOGRAPHIC *and* SURGICAL

Findings in GALLBLADDER *Disease*

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This report is based on the cholecystographic examinations at Emory University Hospital during the year 1952. We have not included 564 survey examinations of the gallbladder which were combined with gastro-intestinal series, and which were considered incomplete examinations not amenable to statistical analysis. There were 14 additional experimental gallbladder studies using different contrast media and different techniques which are not included in this report. The total number of patients having routine cholecystograms was 334, and the total number of examinations was 367. Priodax® was used during the first four and one-half months of 1952 on 118 patients. Telepaque® was used during the remainder of 1952 on 216 patients.

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Radiographic Findings

The final radiographic diagnoses were as follows (See Table 1):

(1) Normal functioning gallbladder without evidence of stones in 222 or 66.5 per cent.

(2) Abnormal findings in 112 or 33.5 per cent. Analysis of the abnormal cholecystographic findings were as follows:

(1) Normal functioning gallbladder with calculi in 33 or 10 per cent.

(2) Poorly functioning gallbladder with calculi in 13 or 4 per cent.

(3) Non functioning gallbladder with opaque calculi in 11 or 3 per cent.

(4) Poorly functioning gallbladder without evidence of calculi in 11 or 3 per cent.

(5) Non functioning gallbladder without evidence of opaque calculi in 44 or 13 per cent.

TABLE I
ROENTGEN FINDINGS IN GALLBLADDER EXAMINATIONS (E.U.H. 1952)

	<i>No. of Patients</i>	<i>Percentage</i>
Total number of cholecystographic examinations	367	100 %
Total number of patients	334	
Normal functioning gallbladder without evidence of calculi	222	66.5%
Abnormal findings	112	33.5%
Normal functioning G. B. with calculi	33	10. %
Poorly functioning G. B. with calculi	13	4. %
Non functioning G. B. with opaque calculi	11	3. %
Poorly functioning G. B. without calculi	11	3. %
Non functioning G. B. without opaque calculi	44	13. %
Total number of patients with calculi on X-ray	57	17. %
Patients with opaque stones	22	6. %
Patients with nonopaque stones	35	11. %

TABLE II
CORRELATION OF RADIOGRAPHIC AND SURGICAL FINDINGS

Total number of patients available for correlation 43				
ROENTGEN	OPERATIVE FINDINGS			
	Chronic Cholecys- titis	Cholelithiasis with		
		Acute & Chr. Cholecys- titis	Chronic Cholecys- titis	Choles- terosis
Normal functioning gallbladder without calculi	2			
Normal functioning gallbladder with calculi			13	1
Poor functioning gallbladder with calculi			7	
Non functioning gallbladder with opaque calculi		2	5	
Poor functioning gallbladder without calculi		1		
Non functioning gallbladder without opaque calculi	1	2	9	
Totals	3	5	34	1

The total number of patients with opaque stones visualized radiographically is 22 or 6 per cent.

The total number of patients with non opaque calculi detected radiographically is 35 or 11 per cent; of course, the non functioning gallbladders containing non opaque calculi are not included in this 11 per cent since they were not identifiable radiographically.

The total number of patients in which calculi were detected radiographically is 57 or 17 per cent of the total number of patients examined, or 50 per cent of the patients with abnormal gallbladders by X-ray examination.

Surgical and Radiographic Correlation

Fifty of the patients had surgery directed toward the gallbladder within a short interval following cholecystography (See Table 2). Of these 50 cases, five did not have cholecystectomies for various reasons. Three of these patients had carcinoma of the liver either primary or metastatic, and in one of these, the primary was apparently gallbladder. Two cases had evidence of gallbladder disease, however, there was inadequate surgical exploration and the surgical findings and radiographic findings could not be compared.

Two patients had had previous cholecystectomies, and obviously would have a non functioning gallbladder, and these must be excluded from a statistical analysis. Actually the number of cases that can be compared radiographically and surgically is then 43. This excludes the five in which surgery was incomplete and the two cases in which cholecystectomy had been performed previously.

Of this group of 43, only two had a radiographic diagnosis of normal functioning gallbladder without evidence of calculi, and in neither of these cases were calculi found at surgery. The pathological report was chronic cholecystitis in both instances; however, the mucosa of the gallbladders was in good condition and the gallbladders were obviously able to concentrate satisfactorily. This discrepancy can not be interpreted as radiographic inaccuracy since the pathological diagnosis of chronic cholecystitis is made in all cases with any evidence of a previous infection.

There were 14 patients having roentgen findings of normal functioning gallbladder with evidence of calculi. In all of these 14 patients, surgery confirmed the presence of calculi. In 13 of them, there was the additional pathological diagnosis of inflammation of the gallbladder, and in one case, there was a pathological diagnosis of cholesterosis of the gallbladder.

Seven patients with poor visualization of the gallbladder with calculi seen radiographically were proven to have calculi surgically and all of these cases had the usual pathological report of chronic inflammation.

Seven patients who had non functioning gallbladders with opaque calculi visualized radiographically had cholecystectomies. In all cases, gall stones were found. In all cases there was chronic cholecystitis and evidence of acute cholecystitis in two.

In one patient with poor visualization of the gallbladder without evidence of calculi, a cholecystectomy was performed. In this case, stones were found as well as acute and chronic cholecystitis, and in restudying the radiographs the stones are clearly demonstrated in one lateral decubitus film. The cause of misinterpretation in this case will be discussed later in this presentation.

Fourteen patients with non functioning gallbladder without opaque calculi were operated. Two of these patients are not included in the statistical analysis since they had had previous cholecystectomies, and at operation were found to have stones in the common duct. Of the remaining 12 patients, 11 had cholelithiasis and cholecystitis, and in one of these, there was a ruptured gallbladder. The remaining patient had chronic cholecystitis without cholelithiasis.

Therefore, in the 43 cases in which we are able to compare the surgical and radiographic findings, it is evident that the radiographic diagnosis was wrong in one case; namely, the case in which stones were not visualized in a poorly functioning gallbladder and stones were found at surgery. There are three additional cases in which there could be some question as to the accuracy of the radiographic diagnosis. In two of these, the radiographic diagnosis was normal gallbladder and the pathological report was chronic cholecystitis. We believe the radiographic interpretation in these two cases was correct as we have mentioned previously. In one additional case, there was a non functioning gallbladder which had a pathological report of chronic cholecystitis without evidence of calculi. This may or may not have been a radiographic error since at the time of the cholecystographic examination, there could have been an acute cholecystitis which would have prevented opacification of the gallbladder. Thus, the best possible percentage correlation would be 97.7 per cent if only the one case with the missed calculi was counted an error. If in addition the case reported only as chronic cholecystitis pathologically in which we reported non functioning gallbladder is counted an error, the accuracy is 95.3 per cent. If this is not counted an error and the two cases thought to be normal radiographically with the pathological report of chronic cholecystitis is counted an error, the accuracy is 93 per cent. Actually we believe the 97.7 per cent figure is correct. This does not give the accuracy of the cholecystographic examination in the entire series of 334 cases, since the accuracy is unknown in the unoperated cases. However, the absence of stones at surgery in the two patients thought to be normal on X-ray is somewhat comforting.

Criteria for Gallbladder Disease

As evidence of gallbladder disease, we accept the following criteria on radiographic study:

- (1) The demonstration of calculi either opaque or non opaque.
- (2) Non functioning gallbladder in the absence of jaundice and in the presence of a residue of

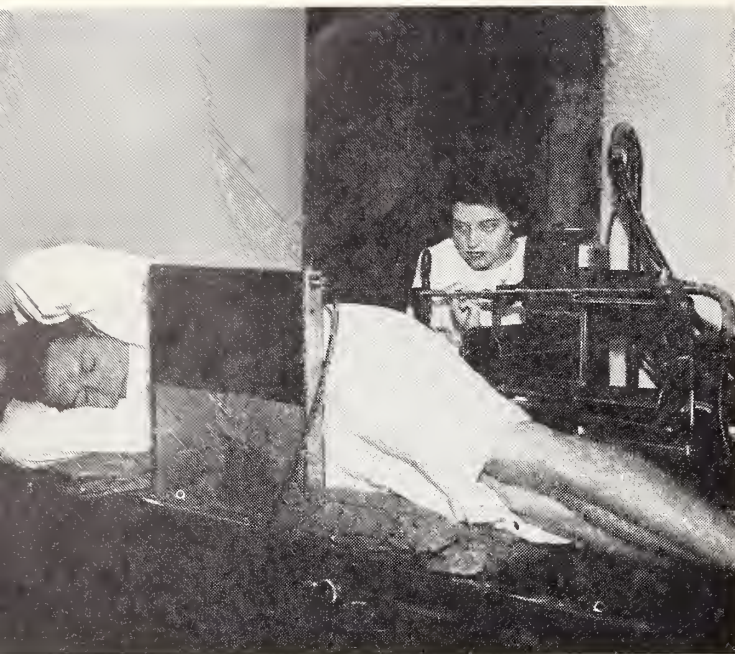


Fig. 1. Right lateral decubitus position for cholecystography. A portable Potter-Bucky diaphragm containing a film is present in front of the patient and the tube is aligned behind the patient. Pillows are used to elevate the right side off the table.

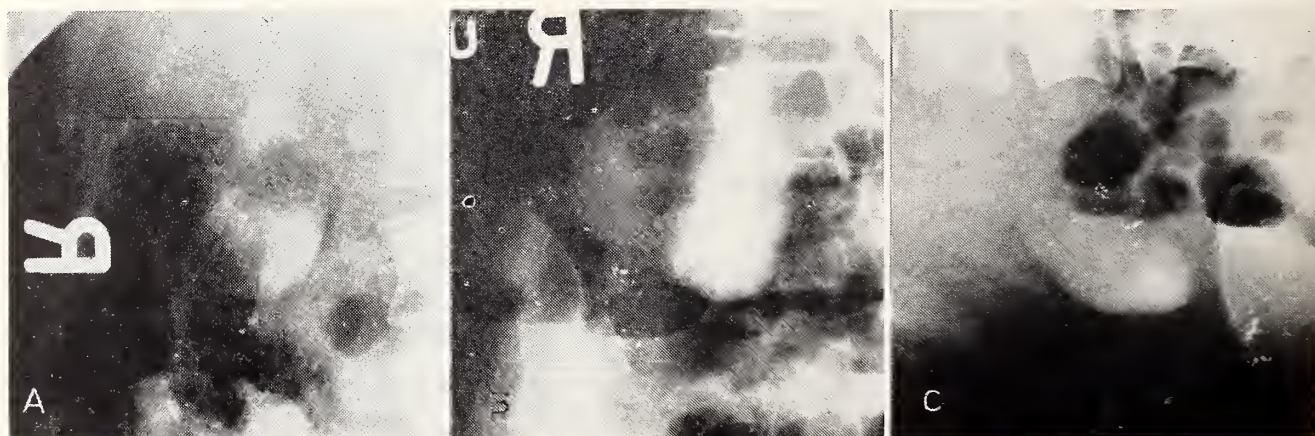


Fig. 2. A. Cholecystogram in prone oblique position. Confusing gas shadows make this film uninterpretable.

B. Some patient in upright position. Gas shadows overlie the dependent part of the gallbladder.

Telepaque® in the colon indicating that the contrast media has been ingested as directed. In all cases of non functioning gallbladder, the examination is repeated.

(3) Very poorly functioning gallbladder in which it is difficult to identify the gallbladder shadow, and in all such cases, the examination is repeated with a larger dose of Telepaque.® In this group of cases, one is most likely to make an error either in the detection of stones or in the estimation of the degree of function of the gallbladder.

(4) The contractility of the gallbladder is not accepted as evidence of disease except in cases of jaundice in which it may influence one in a decision as to the possibility of a partial obstruction of the common duct. In certain cases after the gallbladder contracts, it is easier to identify calculi than before contraction. It is also conceivable that severe disease of the gallbladder wall would limit contraction, however, since contraction is not seen in many normal gallbladders during the course of the examination, this finding can not be accepted in a given case as pathological.

Importance of Positioning

Of the many factors of importance in obtaining diagnostic cholecystographic studies, perhaps the

C. Some patient in decubitus position. No gas shadows are present over the dependent part of the gallbladder. Calculi can now be excluded.

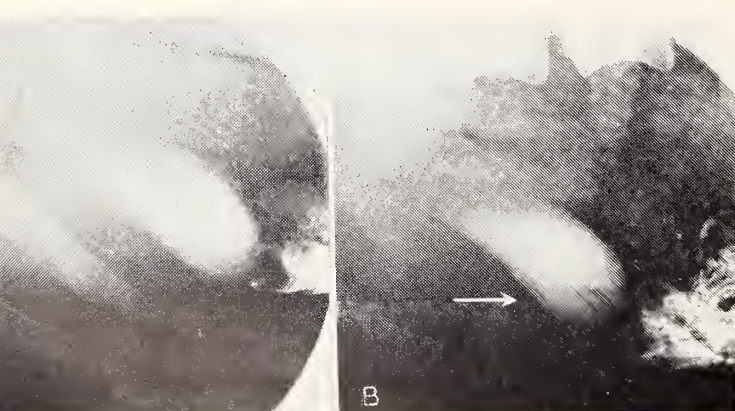


Fig. 3A. Cholecystogram immediately after the patient was placed in right lateral decubitus position—no stones are seen.

B. A film made in the same position 5 minutes later shows innumerable tiny calculi layered out in the dependent part of the gallbladder.

least emphasized and the most important is the employment of a horizontal X-ray beam to disclose layering of small calculi. It is essential to project the dependent part of the gallbladder free of gas shadows with a horizontal beam before calculi can be excluded. The two positions used are the upright position and the right lateral decubitus position as described by Kirklin^{1,2} (See Fig. 1). We find the right lateral decubitus position more satisfactory since there is less interference by gas shadows in the colon, and the gallbladder is much better visualized (See Fig. 2). However, we must bear in mind that a short time interval, of approximately five minutes, should be allowed after the patient is positioned so that small calculi can layer out, since gall stones which have a low specific gravity approaching that of the bile settle out slowly (See Fig. 3). This is demonstrated beyond doubt in the only case in which stones

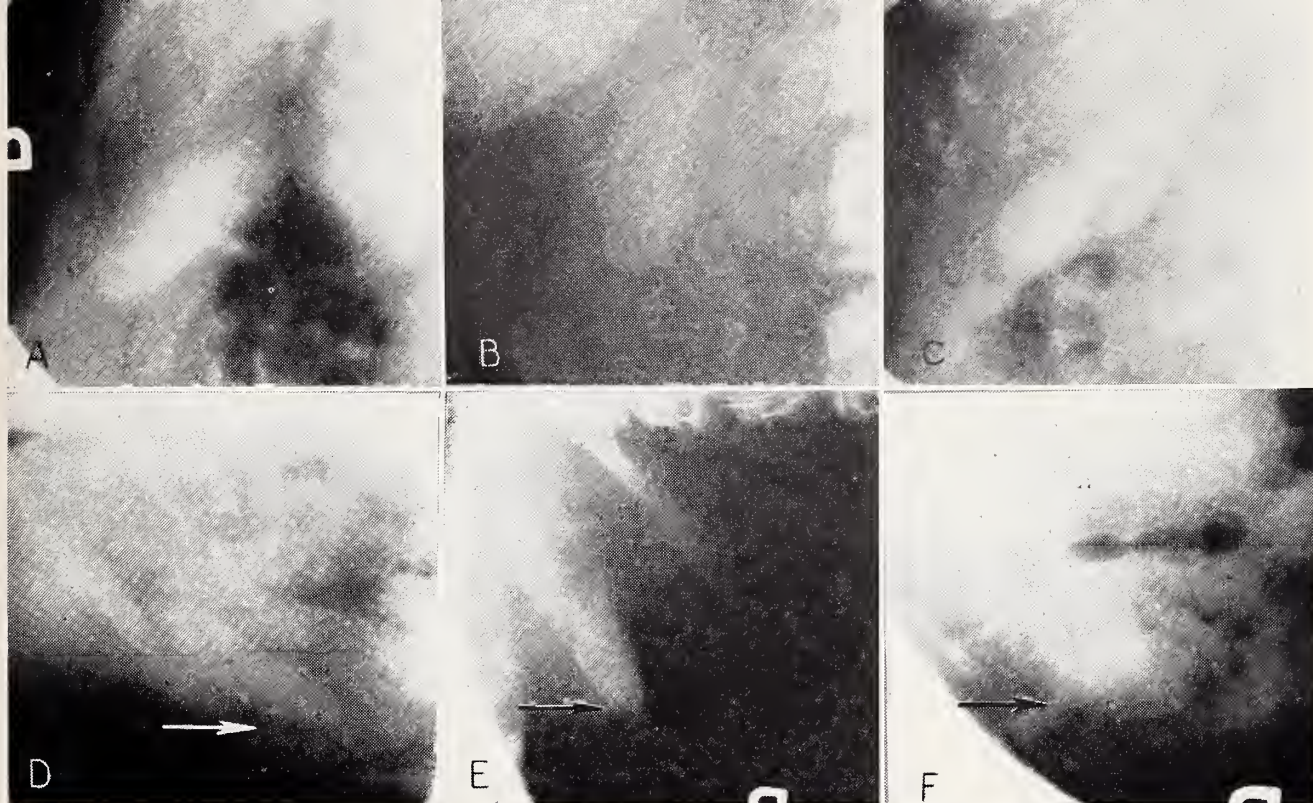


Fig. 4. A. B. C. Prone oblique cholecystograms on three different patients—no calculi are demonstrated.

D. E. F. Right lateral decubitus films on the same three patients showing calculi layered out in the dependent part of the gallbladder.

were not reported radiographically, but were found at surgery in a patient with a poor functioning gallbladder. In this case several decubitus films were made, but in only one can the stones be detected retrospectively. The cause for this is that in the films made immediately after placing the patient in decubitus position the stones were missed since they had not completely layered out, but they are demonstrated in a decubitus film after the patient remained for several minutes in this position.

If the above precautions are observed calculi can be ruled out with certainty, but they cannot be excluded with films taken in only the prone position unless a film study is obtained in which the gallbladder is markedly contracted, and even then errors may be made. To support this contention, of the 47 cases of our series in which gall stones were detected in the functioning gallbladders, the calculi could be demonstrated with certainty only in the decubitus or upright position, in seven cases (See Fig. 4). This is 15 per cent of the cases in which gall stones were demonstrated radiographically or 2 per cent of the total number of patients having cholecystographies. We believe that the latter percentage does not give a real idea of the relative usefulness of the position since a great number of patients without cholelithiasis have been included for comparison of a technique in which only the detection of calculi is concerned. In addition, there were 14 other cases in which only the decubitus position was of value in projecting the fundus free of gas shadows with a horizontal beam, and thus, excluding calculi. This is 4 per cent of the entire series, which added to the 2 per cent in which the stones were demonstrated in the upright and decubitus position in the entire series makes this position of value in at least 6 per cent of the total cases.

Cholecystographic Media

In addition to the decubitus film, there are other factors which are of importance in obtaining cholecystograms of a quality which results in a low percentage error. The technical factors including complete immobilization of the patient, short exposure time, and satisfactory KV and MAS are well understood. The value of Telepaque® as compared with the older media is not yet fully appreciated. The increased opacity of this medium is of definite advantage both in the poorly functioning gallbladder and in the obese patient. Many gallbladders previously thought to be non functioning are visible with this medium. The presence of a small residue of Telepaque® in the colon is of definite value in establishing ingestion and retention of the media by the patient. The objection that Telepaque® is too opaque causing the gall stones to be obscured is not logical, since if the radiologist objects to an opaque shadow, he simply has to reduce the dosage slightly. In any event if the decubitus film is employed, this objection will be avoided. We have also found that the common and hepatic ducts are frequently outlined with Telepaque® as has been reported by others. The lesser side effects with this medium are well known.

Summary

1. A review of 334 cholecystographic examinations performed at Emory University Hospital during 1952 has been carried out and the roentgen findings have been analyzed.

2. The X-ray and surgical findings have been correlated in 43 patients and it has been found that a 93 to 97.7 per cent accuracy in the roentgen diagnosis has been attained.

3. The great importance of positioning, especially the value of the right lateral decubitus position, with allowance of a short time interval before radiographs are taken, has been emphasized in the detection of tiny calculi.

4. The authors feel that Telepaque® is a contrast medium of improved radiopacity, which produces

lesser side-effects than others previously used.

Emory University Hospital

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RECOGNITION

and

TREATMENT *of Infectious*

MONONUCLEOSIS

ROBERT B. QUATTLEBAUM, M.D., Fort Gaines

Infectious mononucleosis has been described as a disease of unknown etiology, characterized by fever, chills, sore throat, enlarged lymph nodes, fatigue and lassitude, enlarged spleen and often jaundice. Due to its protean manifestations and similar hematologic changes, it has been mistaken for diphtheria, meningitis, rheumatic fever, pertussis, appendicitis, leukemia, typhus, measles, scarlet fever, secondary syphilis, typhoid, and infectious hepatitis.

The purpose of this article is to point out that there are probably many sub-clinical cases seen in general practice every day that are not recognized as such. A study made on 210 sporadic cases of infectious mononucleosis seen at the Mayo Clinic demonstrates that the clinical findings suggesting the disease are too indefinite and diverse to serve as final criteria on which to base a diagnosis. Reliance, therefore, must be placed on the laboratory findings. However, to keep in mind that the disease is very

variable in symptoms and physical findings should guide the thoughtful practitioner past the obstacles which beset the unwary.

Several bacteria have been considered as the etiologic agent, but experiments have failed to produce acceptable proof. A filterable virus is now considered most likely. Monkeys innoculated with blood from patients with infectious mononucleosis develop similar blood pictures.

The majority of cases reported in the literature are described as beginning with a severe sore throat, fever, malaise, headache, and enlarged posterior cervical lymph nodes. They are usually noted in young adults, and are more frequent in groups closely associated such as college students and military personnel.

The average leucocyte count is 8,000 in the first week, and 15,500 at the peak of the illness. Standard references on hematology contain excellent illustrations of the familiar large atypical lymphocyte which has a vacuolated cytoplasm and an eccentrically positioned, irregular outlined nucleus. The high lymphocyte count is variable but a differential blood smear

Read before Tri-County Medical Society (Calhoun-Early-Miller), Sept. 16, 1953.

taken on any febrile patient, that shows more lymphocytes than all other cells combined should arouse the suspicion of infectious mononucleosis.

The cytologic changes in the lymphocytes do not usually occur until the second week of the illness, and repeated smears must be made to establish the diagnosis. Many cases are missed because they have a normal differential blood smear during the first week of the illness, and a recheck is not done later. The predominance of any of the various type of lymphocytes seen in the disease does not bear any relation to the clinical course or severity, but when toxic changes are seen in the granulocytes, the clinical course is likely to be severe. Positive heterophil antibody reactions in suspected cases are diagnostic, but a negative reaction should by no means rule out the disease. The antibody titer becomes high only in the second week of the disease and is high only in severe clinical cases. I have seen many patients, especially children, that had typical changes on the differential blood smear, and clinical findings resembling infectious mononucleosis, who had repeatedly negative heterophil antibody reactions. I also have seen many patients that have a leucocyte count of 7,000 or lower, and have a lymphocytosis and the atypical lymphocytes suggestive of infectious mononucleosis. Studies of the sedimentation rate revealed that 75 per cent of patients with infectious mononucleosis have normal rates during the first week. Those having highly accelerated rates during the first week are unlikely to have the disease.

Many authors have denied the presence of "chronic infectious mononucleosis," but patients are frequently seen who complain only of fatigue, lassitude, mild sore throat and variable low grade fever. Physical examination is usually negative except for moderate redness of pharynx. Lymphadenopathy may or may not be present. When it is, the enlarged glands are usually posterior cervical. A differential blood smear shows a high lymphocyte count and many atypical lymphocytes. Keep in mind, however, that these changes do not occur early in the disease but only after the first week. Whether these cases are a sequel to acute infectious mononucleosis or an independent entity is uncertain, but I think their recognition is important in order to prevent massive penicillin and sulfa drug therapy which has proven to be of no value in the treatment of infectious mononucleosis. The recognition of the chronic form is also important to differentiate from other diseases which have a much different prognosis and treatment program. I recently saw a seven-year-old white boy who had been treated for rheumatic fever for three months. At the onset, he had sore throat, fever, joint pains, high sedimentation rate, and leucocytosis. He was given the usual treatment for rheumatic fever with bed rest and a guarded prognosis because of the prolonged fever. He was referred to a cardiologist to determine if there was any heart involvement. A negative report was received and his blood work was repeated. The picture was typical of infectious mononucleosis and after therapy he was allowed to resume

normal activity. Of course, his family was very relieved because of the much more favorable prognosis with no cardiac complications to arise later. Another patient, a 25-year-old Negro male with a diagnosis of lymphocytic leukemia, was seen with fever, severe anemia, generalized lymphadenopathy, enlarged liver and spleen, jaundice and marked loss of weight. A routine heterophile antibody study showed a very high titer and closer examination of the lymphocytes showed them to be the usual atypical cells seen in infectious mononucleosis. After transfusions and active therapy, he had complete remission and two years later has no evidence of recurrence. The distinction between infectious mononucleosis and infectious hepatitis, while often difficult, is not nearly so urgent because the therapy for both illnesses is along similar lines and the immediate and ultimate prognosis of the two is not so widely divergent.

Treatment

No specific therapeutic agent for infectious mononucleosis has been definitely established. Sulfa drugs and penicillin may benefit a complicating streptococcal throat infection. Convalescent serum has given dramatic results in some severe cases. Human plasma and gamma globulin have occasionally appeared to be beneficial. Aureomycin® and Chloromycetin® seem effective in some cases when started early. Hepatitis or liver involvement is extremely common and when it occurs should be treated exactly like cases of acute infectious hepatitis. A program of bed rest for several weeks is very important in the treatment, and the patient should avoid strenuous exercise and abstain from the use of alcohol. A high protein, high carbohydrate, fat-free diet is advisable. Choline and methionine should be used and amino acid intravenously may be helpful as supportive therapy. The most important aspect of the symptomatic therapy in acute infectious mononucleosis is rest. This means the patient should remain in bed at least several days after the temperature returns to normal; he should stay away from work a few days more. Relapses do occur when the patient returns to school or work too early. Fatigue and lassitude are often marked for several weeks, especially in the late afternoon, so extra rest should be prescribed. Some patients have low grade fever and generalized lymphadenopathy for months which no previously reported therapy seemed to influence.

The enlarged and tender lymph nodes seen in the acute stage are best left alone but ice bags help symptomatically. Vincent's infection in the mouth occasionally occurs and sodium perborate is helpful in its treatment. Analgesics and antipyretics should be employed for the pain, headache and fever. Adrenalin spray for edema of pharynx and uvula may help and tracheotomy has been necessary in some cases. Other complications occasionally seen are pneumonia, nephritis and abdominal pain which may simulate a surgical abdomen. Anemia is a reported rare complication but in this series it is very prevalent and whole blood transfusions were an important part of the therapy of the disease.

Carter and Sydenstricker report nine cases benefited by Aureomycin® within 24 to 72 hours after the therapy was started. Only one published report was found on therapy of infectious mononucleosis with Terramycin®. We have used Terramycin® in treatment of five severe acute cases and 16 chronic or sub-clinical cases, which were mostly children under 10 years of age. The clinical course was markedly improved after Terramycin® therapy was instituted, with no known recurrences after six months. The usual recommended doses of the drug were given and it was continued until the patient was afebrile for 24 hours. Symptomatic treatment is still very important and special attention should be given to the hepatic complications and the anemia which usually occur in long standing cases.

If chronic infectious mononucleosis is kept in mind and more careful examinations of the differential blood smears are made, fewer errors will be made in its diagnosis and the morbidity of patients will be reduced.

Summary and Conclusions

1. Attention is called to the number of cases of infectious mononucleosis of the sub-acute or chronic varieties that are probably overlooked in general practice because of the protean nature of the disease, its low mortality but high morbidity and difficulty in differentiation from other febrile diseases.

2. Anemia is a more common complication than has been previously indicated. Whole blood transfusions are very beneficial in the active therapy of the disease.

3. Five severe acute cases and sixteen sub-acute or chronic cases of infectious mononucleosis were treated with Terramycin® with definite improvement and

marked reduction in the morbidity and the duration of the disease.

Fort Gaines Hospital

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Dignitaries at GAGP Session

Officially winding-up proceedings at the Fifth Annual Meeting of the Georgia Academy of General Practice, Hotel DeSoto, Savannah, on October 17 were (left to right, front row) C. F. Holton, MAG Past-President, Savannah; Peter Hydrick, GAGP Past-President, College Park; Alton Ochsner, guest speaker, New Orleans; Harry L. Cheves, GAGP President, Union Point; J. B. Kay, GAGP Past-President and Director, Byron; and (left to right, back row) Maurice F. Arnold, GAGP Secretary-Treasurer, Hawkinsville; Fred H. Simonton, AAGP Delegate, Chickamauga; G. H. Alexander, GAGP President-Elect, Forsyth; Ben K. Looper, GAGP Director, Canton; and W. G. Elliott, GAGP Vice-President, Cuthbert.



Myxedema heart disease, with its cardiac enlargement, diminished output, slow pulse, sluggish action, and various electrocardiographic changes is now a well-established entity, the details of which are available in several excellent reviews. In addition, it is well-recognized that arteriosclerosis, angina pectoris, hypertension, syphilis, chronic nephritis or other renal diseases can be associated with myxedema and may alter the clinical picture. The following case presents several interesting features which we believe were accentuated by myxedema.

CASE REPORT

A 50 year old Negro female was first admitted to Charity Hospital on November 23, 1949, with ascites. The patient was unusually dull with a poor memory for recent events, and consequently, the history was obtained with difficulty. She had noted dyspnea on exertion for the past three years, orthopnea for nine months, followed later by pedal edema and swelling of the hands, eyelids, and abdomen. A physician diagnosed hypertension in September, 1949, and prescribed theobromine, phenobarbital, and digitoxin (the latter in maintenance doses of 0.2 mg. daily). However, the dyspnea and ascites progressed and a slight cough, productive of white phlegm appeared. In addition, the patient had been having convulsive seizures with brief periods of unconsciousness at irregular intervals for the past three years. In May, 1949, she was hospitalized in another institution for "bad heart." Visual acuity had diminished. Constipation was frequent. Some nocturia was present, but there was little urination during the day.

The past history revealed a tonsillectomy in 1944 because of sore throats. She had had one stillborn and one living child, now grown and well. The menopause occurred in 1944. The family history was not contributory. The patient performed house and field work until 1943, but had discontinued because of "asthma and palpitation."

On physical examination the temperature was 97°, the pulse 80 and the blood pressure 195/125. The respiratory rate was 16. Mental reactions were unusually slow and the voice was low-pitched and hoarse. The skin was dry, scaly, and cool. The face and periorbital areas appeared puffy. Some arterio-venous nicking with moderate vascular sclerosis and bilateral macular degeneration was apparent in the fundi. There was advanced periodontoclasia of most of the remaining teeth with marked oral sepsis. The tongue appeared normal. The thyroid gland was not palpable and there was no venous distention in the neck. The lungs were normal. The heart was markedly enlarged; there were no murmurs. There appeared to be a considerable quantity of fluid in the peritoneal cavity; no organs or masses were palpable. Slight pitting edema was noted in the lower extremities. Some osteoarthritis of the knees was present. The vaginal and rectal examinations were negative. Neurological examination was essentially normal.

Laboratory data: The red blood cell count was 2,450,000, the hemoglobin 10 gm., and the hematocrit 34. The leucocyte count was 5,200 with a normal differential. The urine was acid, with a specific gravity of 1.008; tests for sugar and albumin and the microscopic examination were negative. The blood urea nitrogen was 23.8 mg. per cent and the chloride 558 mg. per cent (in terms of NaCl). 60 per cent of PSP was excreted in two hours. Serologic tests for syphilis were negative. The Mantoux 1:1000 was positive. The icterus index was 11.5, the thymol turbidity 3.08, and the cephalin

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The authors wish to thank Dr. John S. Hunt, of the Tulane University Department of Medicine, for helpful criticisms and suggestions in preparing this paper.

Unusual Manifestations

in

MYXEDEMA

*SIMONE BROCATO, M.D.,** Columbus and
ALAN J. LEONARD, M.D., New Orleans

flocculation was negative. There was 8 per cent BSP retention in 45 minutes. Serum protein was 6.81 gm. per cent, with an albumin-globulin ratio of 4.15/2.64. The serum cholesterol (modification of the Bloor, Pelkin, Allen method) was repeatedly elevated—355, 390, 376 and 348 mg. per cent. The X-ray (Figure 1) showed considerable enlargement of the cardiac shadow with a configuration indicating



Figure 1. Chest X-Ray, December 6, 1949. There is massive enlargement of the cardiac shadow, with no evidence of pulmonary congestion.

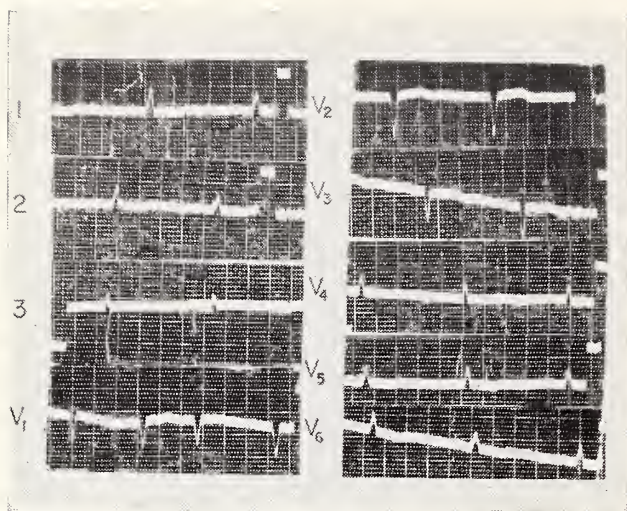


Figure 2. EKG, December 2, 1949. P and T waves low; RI, 2, 3 slurred; compatible with fluid accumulation.

pericardial effusion. An EKG (Figure 2) revealed low voltage throughout, compatible with fluid accumulation.

An abdominal paracentesis on November 23, was productive of 12,000 cc. of straw-colored fluid with a specific gravity of 1.016. It contained numerous serosal cells, lymphocytes, and some albumin, but no malignant cells were found. Eight days later, 6,800 cc. of similar fluid was obtained. On December 8, pericardial tap produced 1,000 cc. of oily, yellow thick fluid with a specific gravity of 1.026 containing numerous cholesterol crystals, fibrin, and macrophages, but no malignant cells. Culture was sterile for acid fast and pyogenic organisms. The next day, an additional 1,400 cc. was obtained. The protein content was 6.3 gm. per cent and the cholesterol 120 mg. per cent. Three days later the cardiac silhouette, visible within a pneumopericardium, appeared to be

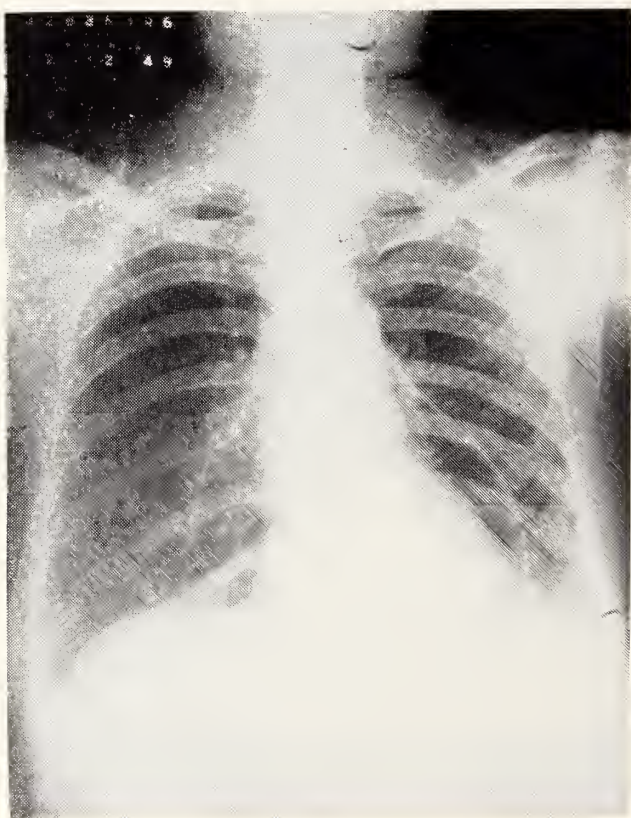


Figure 3. Chest X-ray, after pericardial tap (December 12, 1949). The lung fields are clear. A pneumopericardium is present with an essentially normal cardiac shadow within.

within normal limits. The EKG revealed marked changes as evidenced by an increase in voltage, the appearance of more normal P and T waves, and a left axis deviation (Figures 3 and 4).

Unfortunately, no weight was obtained on admission, but one week later the patient weighed 176 pounds. By December 21, she weighed only 132 and most of the excess fluid had been removed and dissipated. In the absence of edema and dyspnea, it was felt that the BMR determinations at this time were valid, particularly since the effect of hypertension, if any, would be to elevate them. Her metabolic rates were minus 40 per cent, minus 12 per cent and minus 28 per cent respectively. A diagnosis of myxedema was made. It would have been desirable to follow the patient without specific therapy to watch for reaccumulation of fluid, but this was impossible due to ward conditions present at that time. Accordingly, desiccated thyroid, one-eighth grain daily, was begun on December 27, and was gradually increased until February 4, 1950, when two grains daily were being given. She was not given any digitalis, diuretics, or other similar medication.

The patient gradually lost her initial apathy. Her appetite improved and all appearance of edema disappeared, as did the scaliness of the skin. On December 31, she sustained a five second clonic seizure involving only the right arm

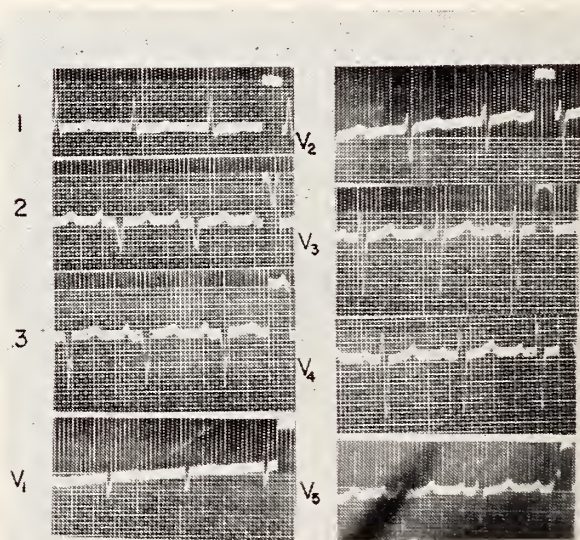


Figure 4. EKG, after pericardial tap (December 12, 1949). Left axis deviation; Small RV 2, 3. QT interval near upper limits of normal. T waves now upright.

(observed only by the other patients) with urinary incontinence. She could not be aroused for five minutes but was normal a short time later. Except for this episode her entire hospital stay was without incident. She was discharged on February 14, 1950, with instructions to continue taking two grains of thyroid daily. Her weight was 138. The EKG and chest film were similar to the ones taken on readmission (Figures 5 and 6).

Second Admission: Three months later the patient was readmitted for further study. The thyroid medication had been continued daily. Her sense of well-being had remained and her weight had continued at about 140. Although her tongue had not appeared definitely thick or unusual before, she volunteered that it was now "easier to handle." There had been only two more convulsive seizures which apparently were similar to the previous ones.

The skin was normal and there was no trace of abnormal fluid accumulation. The speech and mental activity continued to improve. The blood pressure was 175/84. There was only minimal widening of the cardiac shadow on X-ray examination (Figure 5). The EKG (Figure 6) was still suggestive of left ventricular hypertrophy and remained essentially unchanged since the previous tracing.

There appeared to be minimal enlargement of the outflow tract of the left ventricle at fluoroscopy.

The blood picture was essentially unchanged. Repeated urinalyses were normal except for poor concentration. The Fishberg test values were 1.009, 1.009, and 1.012. The cholesterol was reduced to 260 mg. per cent; the blood chloride was 636 mg. per cent. The basal metabolic rates were minus 16, minus 22, and minus 9 respectively. The spinal fluid pressure was 200 mm of water. Normal values were the spinal fluid chloride determination was 727 mg. per cent. found except for a protein of 57 mg. per cent (normal 20-35); An electroencephalogram was reported as follows: "Mixed very fast and very slow record strongly suggestive of convulsive disorder and of generalized depressed cortical activity or damage." The stools were negative for occult blood, ova, cysts and parasites. A barium enema and upper GI series were normal. The patient received a transfusion of 100 cc. of whole blood and was discharged on June 14.

DISCUSSION

We believe the mental, skin, and voice changes, the polyserous effusions, and perhaps the convulsive disorder in this patient were due to hypothyroidism. This is borne out by the improvement on thyroid

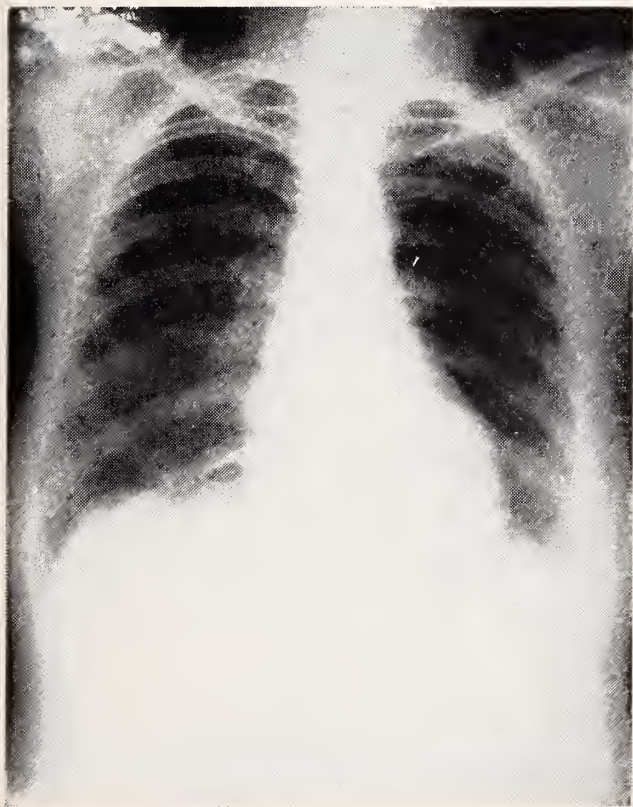


Figure 5. Chest X-ray, May 12, 1950. The lung fields are clear. There is slight enlargement of the cardiac shadow.

therapy, together with the failure of the fluid to re-accumulate without the administration of digitalis and mercurials. In addition, the absence of hypoproteinemia, albuminuria, casts and cellular elements, and the absence of acute retinal changes, congestive failure or cardiac tamponade make it difficult to attribute these to any other cause.

It has been shown that anemia is fairly common in myxedema and that it is also marked at times.

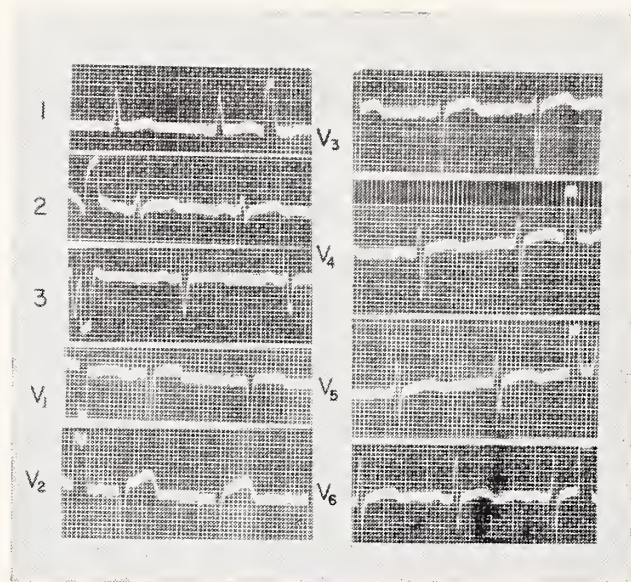


Figure 6. EKG, May 12, 1950. Left axis deviation; Q 2, 3 present and probably due to apex back position of heart. T1 diphasic; suggestive of myocardial disease.

In spite of this, the persistence in this case, together with the elevated blood urea nitrogen and creatinine, and the fixed specific gravity of the urine indicate some degree of nephropathy, the exact nature of which is unknown. With these facts in mind we should like to discuss a few of the interesting findings in this case.

Passive effusions into the serous cavities with hypothyroidism were reported in 1888,³¹ but it was Gordon's report (1928)¹⁰ that emphasized *pericardial* effusions. Other variations of the myxedematous state with and without polyserous effusions, congestive failure, and bladder atony have been reported.^{23 20 6} Apparently the enlarged cardiac shadow may be due to fluid, to changes in the myocardium, or both. In 1948, Kern and his group¹⁶ collected 21 cases of pericardial effusion in myxedema and added four cases of their own. They presented evidence which warranted them to conclude: "Pericardial effusion is a constant, early and major factor in so-called 'myxedema heart'" and it may occur without consequential enlargement of the cardiac shadow. Several illustrations in the literature relate to cases which might well have contained undiagnosed pericardial fluid, and others which probably did not. To us it would seem fair to assume that some are accompanied by fluid accumulation while others are not. The small heart shadow within the pneumopericardium after aspiration in our case (Figure 3) should show that the increased size was due only to the fluid.

Flattening or inversion of the T waves, low or flat P waves and low voltage have been well recognized in the electrocardiograms.²⁹ They may or may not be altered by other pathological conditions as previously mentioned. These

changes, again, have been attributed to pericardial fluid, myxedematous swelling of the myocardial fibers, cutaneous resistance, or anoxemia of the myocardial fibers secondary to sclerosis, anemia, cardiac dilatation, and "nervous etiology." Discussing the above factors, Ohler and Abramson²⁵ concluded that "myxedematous infiltration" was responsible for most of the EKG abnormalities. Thatcher and White²⁹ demonstrated what they felt to be close relationship between the metabolic rate and the height of the T wave in the EKG. Myocardial changes in this condition have been demonstrated. Goldberg⁹ showed that sheep and goats who became "cretinoid" after thyroidectomy developed cardiac dilatation. Alterations consisting of a decrease in the number of fibers, edema, and disappearance of perinuclear sarcoplasm have been produced in the rabbit by Webster and Cooke.³² Interstitial edema with and without fibrosis has been observed in human autopsies.³¹

Our illustrations show the disappearance of the classical myxedematous tracing following pericardio-centesis and the appearance of an EKG more compatible with minimal left ventricular enlargement. The sequence of events suggests that the large cardiac shadow and EKG changes initially presented were both manifestations of fluid accumulation.

The presence of cholesterol crystals in pleural effusions has attracted some attention but little is known of their presence in pericardial fluid. Since the pathogenesis would seem to be closely related we will briefly discuss what has been stated about this phenomenon in pleural effusions. Apparently cholesterol as an ethereal salt is found uniformly in all pleural effusions, but rarely in crystalline form.²⁸ Malaguti,²² in 1929 collected only 44 cases from the literature in which cholesterol crystals were found. They occur most frequently in cases with long-standing primary effusion, coexisting with parenchymal pulmonary disease, or in effusions which arise in the course of pneumothorax therapy, but "in every case the onset of pleurisy has preceded the discovery of crystals by a number of years."²⁵ The incidence of related tuberculosis has varied from less than 25 per cent²² to 52 per cent⁵ in the various discussions. In 1919, cholesterol crystals in the pericardial fluid of a patient with hypothyroidism was reported by Alexander,¹ although he did not know the reason for the fluid accumulation. In light of present knowledge, however, one would almost certainly attribute it to the myxedema heart that was present. Howard¹⁴ reported fluid in the pleural, pericardial and abdominal cavities with myxedema, the latter two containing yellow crystals of cholesterol, the determination being 76 mg. per cent Harrell¹² found 92 mg. per cent cholesterol in pericardial fluid with myxedema but no crystallization was reported. The total amount of cholesterol present may be high or low, and the amount is not necessarily related to the form in which it is found.²² These cases have shown slight or no concomitant elevation of blood cholesterol.

It is interesting that our patient was suffering from periodic convulsions. Unfortunately a spinal fluid examination and electroencephalogram were not done during the initial visit. However, during the second hospitalization, after several weeks of thyroid treatment, examination showed the protein content of the spinal fluid to be elevated to 57 mg. per cent, with a pressure of 200 mm. Elevation of spinal fluid protein has been reported previously by Thompson et al.,³⁰ but pressure readings were not furnished for their cases. In addition they reported the "ratio of the concentration of the chloride of the cerebrospinal fluid to that of the plasma is often less after the administration of dessicated thyroid."

Many psychotic and neurological manifestations have been found in myxedematous patients and these are reviewed fully by Mussio-Fournier²⁴ and Kraus et al.¹⁷ Optic neuritis, vestibular and cerebellar disturbances, coma, spinal paraplegia, and more localized changes have all been reported.^{24 17 27 3 4} Many of these are well-documented and the patients improved with thyroid therapy. Mussio-Fournier writes of a 46-year-old patient entirely well except for a hypothyroid constitution and epileptiform seizures whose fits disappeared with thyroid medication. In discussing two cases of Parker's with nervous and mental features, Haines²⁶ mentioned a patient seen at the Mayo Clinic who also had convulsive seizures. He felt that the seizures in that case were primarily due to arteriosclerosis but had been accentuated by myxedema. Hun and Prudden,¹⁵ in 1888, performed an autopsy on a patient with untreated myxedema who died in coma, and they found gross and microscopic hemorrhages in the cerebellum. Gibbs and Gibbs⁸ illustrate the electroencephalogram of a hypothyroid subject who had been treated which showed an abnormally slow record with frequent bursts of high voltage four to five per second waves in the frontal and parietal leads. These abnormalities are similar to the ones found in the EEG on our patient. With the abnormal EEG, elevated spinal fluid pressure and protein, and the high plasma-spinal fluid chloride ratio (about 121), we believe the convulsive seizures in our patient may have been due to myxedema also.

Just why these patients should develop serous effusions and elevated spinal fluid protein, and why cholesterol crystallization may occur, brings forth another problem. Hanssen¹⁴ attributed the fluid to "the same cause as the subcutaneous oedema" and not to congestive failure or electrolyte disturbances which others have mentioned. With fluorescein dye studies, Lange¹⁸ demonstrated increased capillary permeability which returned to normal after thyroid therapy. He felt that the edema, effusions, and EKG changes were partly secondary to this. Thompson's group³⁰ felt that the elevated protein, etc., were also manifestations of altered permeability of the capillary membranes, but produced no substantiating evidence

as Lange had done. Barbier and Tricaud,² in explaining the occurrence of cholesterol crystals in pleural effusions, felt that with alterations in the serous membranes, the cholesterol passes into the pleural space, undergoes dissociation, and precipitation of insoluble crystals follows.

Summary and Conclusions

An unusual case of myxedema with polyserous effusions, including crystalline cholesterol in the pericardial fluid, and with convulsions is presented. There was considerable improvement with thyroid therapy. The cardiac enlargement and "characteristic" EKG were shown to be due to fluid accumulation. It is probable that the convulsive seizures were due to myxedema also. Some of the literature pertaining to these features was discussed.

1509 Fourth Ave.

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Worth County Sets An Example

Worth County Medical Society is one of the most active county societies in the state. The small, five-member organization is a fine example of what many of the larger and older societies are not doing. Headed by H. G. Davis of Sylvester, president, and W. P. Stoner of Sylvester, secretary-treasurer, the group meets each month at a hotel or residence of one of the members. No dues are levied, but each doctor takes turn as host for the dinner meetings. Since all of the members are also on the staff of the

Sylvester Hospital, hospital staff meetings are held together with the medical meetings. Results of the work of this active society, which only began meeting regularly nine months ago, have already become evident, according to Dr. Stoner. "Our relations with each other have improved tremendously since we became active," he declared. "Before last April, things weren't as smooth between doctors in the county as they are now," he said. In addition to the active Medical Society, Worth County boasts an equally active Woman's Auxiliary.

This article is third in a series on medical economics. Some 87,000 reprints of the first article, "Can You Retire Doctor?", by Dr. Robert Scharf, Associate Professor, Georgia Institute of Technology, have been requested for distribution throughout the U. S.

THE GREAT FALLACY:

Term Insurance + Stock Investment = Financial Security

ROBERT SCHARF, Ph.D., Atlanta

The voices of financial consultants never tire of recommending in non-professional magazines their formula of "Term Insurance + Stock Investment = Financial Security." Unfortunately their argumentation does not reveal that inter-disciplinary knowledge necessary to give equal weight to the cross-cutting factors which are needed in order to understand the elements of financial security.

These "estate and finance doctors" suggest in their writings basically: (a) the accumulation of savings for the purpose of retirement; and until this goal has been reached, (b) the purchase of enough life insurance in case of premature death. However, in order to leave enough means for savings, the lowest premium rates—term insurance—will do, they assert, because if you spend too much on life insurance, you may not have enough left for retirement. Besides, life insurance, they maintain, was never intended to be an instrument for building an estate. Just buy enough life insurance, namely renewable term to age 70, to protect your family. The balance of your savings should be put to work "productively and safely." At best, buy shares in a conservative mutual fund.

An article, recently published in an economic magazine widely distributed among physicians all over the United States, recommended \$60,000 term insurance to age 70 with an annual premium outlay of about \$800. Well, what is wrong with term insurance? Nothing, if short term. But according to the National Office of Vital Statistics, Department of Health, Education and Welfare, the expectation of life at age 70 in the United States in 1950 has been 10.3. This means that the average white male who reached the age 70 in the United States in 1950,

can expect to live to age 80. Consequently the man who follows the advice of the magazine in question will have paid about 40 annual premiums of \$800, or over \$32,000 and as he will die most probably beyond age 70, his heirs will not collect a penny from his term insurance, but the insured himself at retirement age will be poorer for \$32,000.

The next advice given to our physicians is to turn over their savings above the premium payments to a trust department. However the writer warns that for trust departments of small banks it may not pay to employ an investment expert and on the other hand, in his own words "some of the biggest banks in the country, whose competence is beyond question, have sometimes had so many trust accounts that they could not give adequate attention to all of them." Therefore our expert deems it important to hire investment managers independent of the bank, either by making use of the services of an investment counsel firm or by buying mutual investment funds which are most conservative in the stocks and bonds investments of your cash savings. Of course, he emphasizes, it will be necessary "to check up on your mutual investment funds, so if they ever seem to be slipping, you can fire them by taking your money out and putting it into another fund." For the services of your investment managers who operate the mutual fund you buy into, you will pay, he advises, about 8 per cent of whatever you invest.

We agree with our finance experts that where investments are concerned nothing is absolutely certain. Just let us see, what the big investment broker

firm of Merrill Lynch, Pierce, Fenner and Beane in its July 1953 magazine *Investor's Reader* has to say about post war high and recent low notations of stocks: Here are a few of 300 stocks which are far below their recent values:

	Approximate Post War High	Recent Low
Decca Records	37	9
Walt Disney Production	22	8
Packard Motor Car	12	5
Pepsi Cola	40	13
Cudahy Packing Company	20	7
Florence Stove	57	20
Crowell-Collier Publishing	46	6
Adam Hat	22	4
R. H. Macy	65	22
Wallgreen	54	25
Hart Schaffner & Marx	60	23
Delta-C. & S. Airlines	69	25
Pan American Airways	29	10

But let us be optimistic and follow the counsel of our financial experts. Let us suppose your stocks and bonds will go up and will yield a 5 per cent return. And suppose you are in the \$20,000 income tax bracket and that you invested, let us say, \$10,000. The gross return on \$10,000 with 5 per cent would be \$500. Your income tax on a joint return basis would be 42 per cent. Therefore you would receive \$500 less 42 per cent or \$290. But this means a net profit of 2.9 per cent only. Should you be in the unfortunate position of having a taxable income of \$40,000, your investment yield of \$500 at 62 per cent income tax would be merely \$190 or 1.9 per cent. So you take a 5 per cent risk for 2.9 per cent or 1.9 per cent return. This raises the question of whether it pays at all to take investment chances for such small rewards. Have you ever thought of this? Whether your stock goes down or up, you lose.

Another very important point is overlooked by nearly all investment counselors: that there is only one form of property which provides tax free income. And this is life insurance property. Namely since 1934, the law says that an income from a matured life insurance policy is not taxable as such, but that the owner of such a policy has to report as income only 3 per cent of the purchase price each year. Let us analyze the implications of this law.

An article "It's the World's Best Property," by Wallace H. King in the July 1953 edition of *The Pelican*, monthly magazine issued by one of our largest life insurance companies, describes the actual history of his own policy No. 1,175,514 issued January 23, 1925 at his age 32 in the face amount of \$100,000. This policy has been taken out originally as an Ordinary Life policy in order to obtain maximum protection at low cost. The average annual premium less dividend from 1925 to 1936 was \$2,000. In

1937 Mr. King had his policy changed to Retirement Income at 65 and in 1939 it was changed to Retirement Income at 60.

He paid on total premiums from 1925 to 1953 to age 60—\$123,726.24. The maturity value at age 60—\$169,837.00. Net profit (NO INCOME TAXES ON THIS YET)—\$46,110.76. Guaranteed monthly income from this value—\$1,092.05. THIS INCOME CANNOT BE OUTLIVED. Expected results during life expectancy of a man of age 60—\$190,016.70. Add five years' income, because an annuitant has a life expectancy five years greater than normal—\$65,523.00—making a total expected return of \$255,539.70.

And, adds Mr. Wallace King, if he should live to be as old as his father, John P. King, the total return of his \$100,000 policy will be—\$347,271.70.

Besides this, Mr. King emphasizes that his contract never experienced any depreciation in its market value—even in the 30's, because all values are guaranteed in the contract and backed by an institution over 100-years-old with over a thousand million dollars assets, and not less important, on the net profit of \$46,110.76 no income tax had to be paid up to now!

But, how about the income tax situation now? He must report 3 per cent of the purchasing price of his life insurance policy, on \$123,726, which amounts to \$3,831.78. At age 65, he will have an exemption of \$1,200 and when his wife will be 65, she, too, will have an exemption of \$1,200. In other words, he will have to pay \$1,413 annual income tax only and will obtain \$11,691 per annum INCOME TAX FREE.

Now, let us assume, Mr. King had followed the advice of an investment expert and he would have accumulated over the years \$123,726 in stocks, bonds or real estate and IF he had not had losses occurred during all those 28 years and if at older age he would invest in sure investments with 3 per cent only (who likes to take chances at old age?) he would have an income of only \$3,711.76. The life insurance way will use up his principal. But so would the other investment method, because the relatively small interest income would not satisfy a man of previously higher income habits. Therefore it would cause him to supplement his retirement income from principal. Thus it would reduce the principal every year for a few thousand dollars and at the same time reduce the interest income proportionally.

What other logical conclusion can we come to, than to invest in a good life insurance company, where you don't need to pay 3 per cent to a trust company for administration and an 8 per cent fee to an investment manager, which again would decrease the net yield from your investment. The life insurance company eliminates your investment and re-investment worries and distributes free of charge after your death the proceeds of your policy according to your wishes laid down in the policy. Your interests are protected by state law. Should you

have to borrow on your stocks in case of emergency, you may not get more than about 60 per cent of the stock value and if the stock should go down, you certainly would have to put up additional collateral or otherwise your loan will be called. But you can borrow your full and guaranteed cash value of your life insurance policy and you can pay back your loan whenever it will be convenient to you. In case of loss of your income through sickness or accident, you would most probably have to stop buying new stock, but your life insurance company will go on paying the same amount you paid every year and so your retirement savings will continue—paid for by the life insurance company. Which bank or mutual fund investment institution will do this for you?

It is by no means the intention of this writer to eliminate the stock and bond market as a medium

of investment entirely. If, after a sound life insurance investment program has been set up and then, there are still means left for other investments it is not only patriotically imperative to buy government bonds but also a good insurance against communism to help our own industry to obtain working capital.

But we should never forget that when we are old, we don't need money in the bank. What we need is a **GUARANTEED** income which neither we nor our wives can outlive.

If we talk insurance, we mean to **MAKE SURE**. Anything else in the investment field is based on hopes.

When will this great fallacy and economically so unsound formula "Term Insurance + Other Investments = Financial Security" be discarded from the sales talk of our financial consultants?

630 First National Bank Bldg.

Medical Exhibit

at Fair-A-Ganza



Nurses wait, above, for prospective applicants to register at the booth which the MAG and Fulton County Medical Society sponsored at the recent Southeastern Fair, Atlanta. At left are "Faces of the Hospital," photographs illustrating the job of a

technician in a modern hospital. At right, is an AMA exhibit called "Fooling the Fat," which demonstrates fake methods of losing weight. The booth was set up by the MAG Public Relations Committee and was staffed by nurses and technicians from several Atlanta Hospitals.

Report of

MAG COUNCIL MEETING

Savannah, October 18, 1953

The Council of the Medical Association of Georgia met on Sunday, October 18, at 10 a.m., at the Hotel DeSoto, Savannah, with the following present: H. L. Cheves (chairman), Wm. P. Harbin Jr., David Henry Poer, Peter B. Wright, Charles T. Brown, Clarence Palmer, James M. Hicks, W. Bruce Schaefer, D. Lloyd Wood, W. G. Elliott, George R. Dillinger, Mark S. Dougherty, J. Victor Roule, Milford B. Hatcher, H. Dawson Allen, J. W. Chambers, Lee Howard, Howard Morrison, R. L. Schley, Jr., Dixon Fowler, Neal Yeomans, C. F. Holton and Mr. Sid Wrightsman, Jr.

The following action was taken:

1. *Instructed* Councilors and Vice-Councilors to attend the AMA-sponsored VA conference in Atlanta on November 8.

2. *Approved* belated award of Life Membership to Alice Moses, Columbus and Wallace H. Clark and Reuben S. O'Neal, LaGrange.

3. *Authorized* payment of \$200 each to AMA Delegates Allen and Richardson for expense in connection with attendance at the AMA Clinical Session, St. Louis, December 1-4, and full travel expense for attendance thereat by Assistant Secretary Mark S. Dougherty.

4. *Approved* a flat fee of \$150 per 4 x 8 ft. booth to be charged all commercial exhibitors at the 1954 Annual Session in the Municipal Auditorium, Macon.

5. *Authorized* Council Committee on Audit and

Appropriations to approve "unexpected" committee expenses occurring through the end of the current fiscal year, ending December 31, 1953.

6. *Approved* the Georgia Study of services for handicapped children to be conducted in Clarke County by the Georgia Society for Crippled Children subject to the following conditions: (a) That the survey should be made with the approval of the Clarke County Medical Society. (b) That handicapped persons included in the survey, and under the care of a private physician, should be included only on approval of that physician, and that medical information and the diagnosis be recorded from the private physician. (c) That any legislation which might be suggested as a result of this survey should have the approval of the MAG. (d) That the diagnosis in each established case be transmitted back to the private physicians involved. (e) That existing medical facilities in the State be listed, which in any way render service to crippled children.

6. *Instructed* President Harbin to appoint an "interested" committee to represent the Association in an advisory and consulting capacity to the above described survey.

8. *Authorized* reimbursement to Chairman Joiner of the VA affairs committee for his travel expense connected with attendance at the AMA VA conference in Chicago on September 1st.

9. *Authorized* the Executive Committee of Council to approve all future policies affecting headquarters office personnel.

The meeting adjourned at 12:20 p.m.

Report of MAG LEGISLATION

Committee Meeting, Atlanta, October 8, 1953

A meeting of the Committee on Legislation, Carl C. Aven, chairman, was held at the Academy of Medicine at 4 p.m. October 8, Atlanta. Present in addition to Aven were Jack C. Norris, Atlanta, and Joseph D. McElroy, Atlanta. Subcommittee members present were Sam Garner, Rome, T. Peterson, Savannah, Virgil B. Williams, Griffin,

Marcus Mashburn, Sr., Cumming and T. F. Sellers, Atlanta. Also present were William P. Harbin, Jr., Rome, Lester Petrie, Atlanta and Messrs. Sid Wrightsman and John F. Kiser of the MAG headquarters staff. Pending federal and state legislation was discussed and subcommittees were appointed to study specific bills. The group adjourned to a dinner at the Biltmore Hotel Grill.

Report of

MAG RURAL HEALTH

Committee Meeting, Atlanta, October 25, 1953

Attending a meeting of the Committee on Rural Health of the Medical Association of Georgia October 25 at 4 p.m. at the Academy of Medicine, Atlanta, were the following members: W. W. Turner, Nashville, chairman; Charles Brown, Guyton; Clarence Palmer, Covington; Sterling Jernigan, Atlanta; Joe Arrendale, Cornelia; Lynn Huie, Monroe; T. A. Sappington, Thomaston; E. B. Claxton, Dublin. Also present were William Harbin, Rome; Peter Wright, Augusta; David Henry Poer, Atlanta; S. C. Rutland, Atlanta; Miss Doris Webb, Chicago; Mrs. Leo Smith, Waycross; Mrs. Annie Laurie Reid, Atlanta; Mrs. Shelley Davis, Atlanta, and Messrs. M. D. Krueger and J. F. Kiser, MAG headquarters representatives.

Miss Webb, Staff Assistant handling placement service operations for the AMA's Council on Medical Service, gave Committee a presentation on Doctor Placement problems in the U. S. today. Miss Webb described what the AMA is doing to help state societies improve their placement services. She also discussed doctor placement on the local level.

Committee action was as follows:

1. *Approved:* That each member of the Committee be responsible for assessing locations seeking physicians in their respective districts and also aid

physicians seeking locations in their area to facilitate the MAG doctor placement service.

2. *Approved:* That *JMAG* publish monthly lists of locations available in the state and names of physicians seeking locations in Georgia, as an adjunct of the Doctor Placement Service.

3. *Recommended:* That doctor placement service lists showing locations seeking physicians be brought to the attention of the medical students, interns and residents in Georgia.

4. *Approved:* That an informal talk on the opportunities of general practice in Georgia be given to the graduating medical students at Emory University School of Medicine and the Medical College of Georgia.

5. *Approved:* That the Committee work more closely with the Better Health Council of Georgia and that the Rural Health Committee members serve on the Board of Directors of The Better Health Council.

6. *Approved:* That the executive secretary of the Better Health Council of Georgia and the president of the Woman's Auxiliary to the Medical Association of Georgia serve in an ex-officio capacity at all Rural Health Committee meetings.

The meeting adjourned at 6 p.m.

Report of MAG BLOOD BANK

Committee Meeting, Atlanta, October 23, 1953

Attending a meeting of the Committee on Blood Banks of the Medical Association of Georgia at the Academy of Medicine October 23 at 7:30 p.m. were the following members: J. C. Thoroughman, Atlanta, chairman; W. L. Sheppard, Augusta; Frederick H. Thompson, Albany and George Dowling, Atlanta. Also present were E. M. Dunstan, Atlanta, Mrs. Betty DeVon, Atlanta, State Health Department; John R. DeVellina, Jackson, Miss., Red Cross and Mr. John Kiser, Atlanta, MAG headquarters representative.

The Committee recommended the formation of a committee to set up minimum standards for the typing, grouping, cross-matching and storage of

blood in Georgia hospitals. The Committee on minimum standards is to be composed of representatives of the following organizations: State Health Department, Georgia Association of Pathologists, Georgia Hospital Association, Red Cross, American Association of Blood Banks, Medical Association of Georgia and the Georgia Society of Medical Technologists.

The Committee also agreed to accept an invitation of the Georgia Society of Medical Technologists to present a program on the operation of blood banks at the annual session of the Society, April 9-11, at Columbus.

The meeting adjourned at 10:00 p.m.

Report of

MAG MATERNAL *and* INFANT WELFARE

Committee Meeting, Atlanta, October 27, 1953

At a meeting of the MAG Maternal and Infant Welfare Committee held at the Biltmore Hotel, Atlanta, at 8:30 a.m., October 27, 1953, the following representatives were present; Peter Hydrick, Chairman, College Park; Helen W. Bellhouse, Secretary, Atlanta; Fred H. Simonton, Chickamauga; Mark S. Dougherty, Atlanta; Thomas C. McPherson, Atlanta; and Messrs. Milton D. Krueger and John F. Kiser, MAG headquarters office, Atlanta.

Peter Hydrick called the meeting to order at 8:30 a.m. and led discussion on the proposed action for Committee consideration. The following recommendations were made and approved by the Committee members:

(1) *Recommended:* That MAG President William Harbin appoint a subcommittee to the Maternal and Infant Welfare Committee composed of one member from each district medical society to represent the Committee and their aims at the district society meetings.

(2) *Recommended:* That the appointed members of the Subcommittee on Maternal and Infant Welfare are to appoint a member from each county medical society within their district to represent the Committee and their aims at the county medical society meetings.

(3) *Approved:* With suggestions, proposed revision of Live Birth and Fetal Death Certificates for use in the state of Georgia.

(4) *Recommended:* That members of the Subcommittee on Maternal and Infant Welfare bring to the attention of the district and county societies the revised Live Birth and Fetal Death Certificates with an adequate explanation on the purpose and use of these forms.

(5) *Approved:* The sending of a letter to every physician in Georgia concerning the revised Live Birth and Fetal Death certificates along with a reference to the state of Georgia law concerning these certificates. (This recommendation will be forwarded to the Vital Statistics Department of the State Department of Public Health.)

(6) *Approved:* That the Maternal and Infant Welfare Committee Secretary Bellhouse disseminate all relevant statistics and literature from other states to the members of the Committee.

(7) *Recommended:* That the Maternal and Infant Welfare Committee transmit their suggestions concerning the choice of a guest speaker for the MAG Annual Session, 1954, to the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatrics Society.

(8) *Recommended:* That an exhibit of the Maternal and Infant Welfare Committee be prepared as a scientific exhibit for the MAG Annual Session, 1954. Designated Helen Bellhouse as Committee member responsible for this exhibit.

(9) *Recommended:* That the Maternal and Infant Welfare Committee be officially represented at the Tri-State Obstetric and Pediatric Seminar at Daytona Beach, Florida, 1954 and the Saluda Obstetric Seminar. The Committee also approves these Seminars and suggests that sufficient space be allotted in the JMAG to advertise these meetings.

(10) *Recommended:* That the MAG Legislation Committee investigate the feasibility of changing the sterilization laws in Georgia to clarify the physician's legal status when sterilization is performed for other reasons than insanity. The uniformity of application in Georgia hospitals was advocated. The Committee wishes a report on this matter from the Legislation Committee.

(11) *Recommended:* That a member of the Maternal and Infant Welfare Committee be designated to review contraceptive methods approved by the MAG and now recommended by the State Department of Public Health. This member will function in an advisory capacity.

(12) *Approved:* The continuation of brief editorials to run monthly in the JMAG with pertinent maternal and infant welfare statistics and data.

The Committee designated as their next meeting date and place—January 17, Dempsey Hotel, Macon for 1 p.m. luncheon.

The meeting adjourned at 10:10 a.m.

ANNOUNCEMENTS

NOVEMBER 23: Walker-Catoosa-Dade Medical Society will meet at 8 p.m. at the Tri-County Hospital, Fort Oglethorpe.

NOVEMBER 24: Polk County Medical Society will meet at 7:30 p.m. at the Wayside Inn, Cedar-town.

NOVEMBER 24: Muscogee County Medical So-cietiy will meet at 7:30 p.m. at the Standard Club, Columbus.

NOVEMBER 30: Gordon County Medical So-cietiy will meet at 7:30 p.m. at Calhoun.

DECEMBER 1: Health Conference, featuring a panel on School Child Health, at the University of Georgia, Athens, sponsored by the Better Health Council of Georgia.

DECEMBER 1: Upson County Medical Society will meet at 7:30 p.m. at the Upson County Hospital, Thomaston.

DECEMBER 1: Tift County Medical Society will meet at 7:30 p.m. at the Tift County Hospital, Tifton.

DECEMBER 1: Bibb County Medical Society will meet at the State Health Department or Pine-brook Inn, Macon.

DECEMBER 1: Hall County Medical Society will meet at 7:30 p.m. at the Avon Restaurant, Gaines-ville.

DECEMBER 3: Coffee County Medical Society will meet at 1 p.m. at the Douglas Hospital, Douglas.

DECEMBER 3: Fulton County Medical Society will meet at 7:30 p.m. at the Academy of Medicine, Atlanta.

DECEMBER 3: Ware County Medical Society will meet at 7:30 p.m. at the Okefenokee Country Club, Waycross.

DECEMBER 3: The 6th District Medical So-cietiy will meet at Macon.

DECEMBER 3: Habersham and Stephens County will hold a joint meeting at Toccoa.

DECEMBER 4: Jenkins County Medical Society will meet at 7:30 p.m. at the Screven County Hos-pital, Sylvania.

DECEMBER 4: Chattooga County Medical So-cietiy will meet at 7:30 p.m. at the Chattooga County Hospital, Summerville.

DECEMBER 4: Burke County Medical Society will meet at 7:30 p.m. at Sylvania.

DECEMBER 7: Cobb County Medical Society will meet at 7:30 p.m. at the Kennestone Hospital, Marietta.

DECEMBER 7: Telfair County Medical Society will meet at 8 p.m. at the Telfair County Hospital, McRae.

DECEMBER 8: Altamaha Medical Society will meet at 8 p.m. at the Appling General Hospital, Baxley.

DECEMBER 8: South Georgia Medical Society will meet at 7:30 p.m. at the Country Club, Valdosta.

DECEMBER 8: Decatur-Seminole Medical So-cietiy will meet at Bainbridge or Donalsonville.

DECEMBER 9: Tattnall County Medical Society will meet at 1 p.m. at the County Court House, Reids-ville.

DECEMBER 10: Jefferson County Medical So-cietiy will meet at 8 p.m. at the Jefferson Hotel, Louisville.

DECEMBER 11: Randolph-Terrell Medical So-cietiy will meet at 8 p.m. at the Patterson Hospital, Cuthbert.

DECEMBER 14: Walton County Medical So-cietiy will meet at 7:30 p.m. at the VFW Home, Monroe.

DECEMBER 14: DeKalb County Medical So-cietiy will meet at 7:30 p.m. at the DeKalb County Health Building, Decatur.

DECEMBER 15: Spalding County Medical So-cietiy will meet at 6:45 p.m. at the Griffin-Spalding County Hospital, Griffin.

DECEMBER 16: Whitfield County Medical So-cietiy will meet at 7:30 p.m. at the Hamilton Me-morial Hospital, Dalton.

DECEMBER 16: Worth County Medical Society will meet at 8:00 p.m. at Sylvester.

DECEMBER 17: Fulton County Medical So-cietiy Annual Meeting.

DECEMBER 17: Richmond County Medical So-cietiy will meet at 7:00 p.m. at the Old Medical Col-lege, Augusta.

DECEMBER 17: McDuffie County Medical So-cietiy will meet at 8 p.m. at the McDuffie County Hospital, Thomson.

SOCIETIES

Second District Medical Society met at the Sunset Country Club, Moultrie, on October 1 at 3 p.m. During the preliminary business session, Rudolph Bell, Thomasville, was named Second District candidate for president-elect at the 1954 Annual Session. In the scientific session, E. R. Cook, III, Savannah, read a paper, "The Nature and Management of Hypertension and Hypertensive Disease." J. P. Tucker, Bainbridge, read a paper, "Arthritis in General Practice," and J. H. Brannen, Albany, spoke on "The Treatment of Urethritis in Women."

Following the scientific session David Henry Poer, Atlanta, MAG Secretary - Treasurer, met with presidents and secretaries of the County Societies to discuss problems of organization on the County Society level. A buffet dinner was served at the Country Club. Members of the Woman's Auxiliary, who had heard a talk by Mrs. Shelley C. Davis, of Atlanta, president-elect of the Woman's Auxiliary to the MAG, during the afternoon, met with the Society for the social session. The next meeting of the Society was set for the first Thursday in April at Thomasville.

Fifth District Medical Society met at the Academy of Medicine, Atlanta, November 5. The speaker was Dr. Frederic N. Silverman of Cincinnati, Ohio, who talked on "Urologic Problems in Pediatric X-ray Diagnosis." Given special recognition at the meeting were the officers: J. Harry Lange, president, W. S. Dorrough, vice president and Purcell Roberts, secretary-treasurer.

Seventh District Medical Society met at the Chattooga County Memorial Home at 2 p.m. October 14. An address of welcome was delivered by John J. Allen, Trion. Councilor Lloyd Wood, Dalton, gave a report of Association-wide activities. H. L. Erwin, Dalton, District President, introduced Mr. John F. Kiser, Atlanta, new assistant executive secretary at MAG headquarters.

Scientific papers were read by Robert D. Walters, Calhoun, "That Open Car Window;" Raiden Delinger, Rome, "Peri-nephritic Abscess;" Oscar B. Murray, Chattanooga, Tenn., "Genito-Urinary Injuries Following Pelvic Surgery," and Warren M.

Gilbert, Rome, "Sterility." Discussants included William Hyden, Trion; Lee Battle, Rome; Foster Hampton, Chattanooga; Lloyd Wood, Dalton, and Robert Norton, Rome. District members voted to levy dues of \$5 per member to pay for meetings and programs. It was decided that the next meeting would be held in Rome. The members adjourned to a delicious barbecue dinner served on the grounds of the Memorial Home.

Eighth District Medical Society met at the American Legion Home in Waycross, October 13 at 2:30 p.m. Scientific papers were read by W. C. Calhoun, Waycross, "The Management of Obstetrical Difficulties," and by W. L. Flesch, Waycross, "New Concepts in the Etiology and Treatment of Prostatic Disease." Leading the discussions were T. J. Ferrell and W. F. Reavis, both of Waycross.

William Harbin, Rome, MAG president, addressed the meeting. Eighth District councilor N. F. Yeomans, Waycross, also gave a report. H. T. Atkins, Waycross, was elected president of the Society succeeding F. G. Eldridge, Valdosta. Van Bennett, Valdosta, was elected vice president. Sage Harper, Douglas, will serve as secretary-treasurer for the third year of a three-year term. The next meeting of the Eighth District Medical Society will be held the second Tuesday in April at Douglas.

Cherokee - Pickens Medical Society met for a dinner meeting September 25 at the Hotel Canton. Host and hostess were Dr. and Mrs. Bob Jones. The guests included Dr. and Mrs. Grady Coker, Dr. and Mrs. C. R. Andrews, Jr., Dr. and Mrs. Arthur Hendrix, Dr. and Mrs. W. H. Nichols, Jr., Dr. B. L. Looper, all of Canton; Dr. and Mrs. C. J. Roper, Dr. E. A. Roper, Dr. and Mrs. G. H. Perrow, Jasper, Dr. and Mrs. Marcus Mashburn, Cumming and Dr. and Mrs. George T. Nicholson, Cornelia.

Georgia Medical Society met at 612 Drayton Street, Savannah, at 8:30 p.m. Tuesday, October 13. Principal speaker was Dr. M. Fernan-Nunez, Chief of Laboratory Service, Veterans Administration Hospital, Dublin. His topic was "Cerebral Vascular Accidents."

Habersham County Medical Society held a joint scientific meeting with the *Stephens County Medical Society* November 5 at the Commercial Hotel, Cornelia. The guest speaker was Dr. John L. Barner, Athens, who talked on "Carcinoma of the Cervix." Members of the Hart County Medical Society attended as guests.

PERSONALS

E. B. Agnor, Atlanta, announces the removal of his office to 1211 W. Peachtree St., N.E., Atlanta, for the practice of internal medicine.

Georgia doctors named Fellows in the American College of Surgeons at the meeting in Chicago include

Alfred M. Battey, Jr., Moffat H. Wylie, Louis O. Manganiello, J. Victor Roule, Augusta; Thomas Freeman, William H. Lippitt, Savannah; Frank B. Mitchell, Jr., Brunswick; Abram B. Daniel, Statesboro; William B. McMath, Americus; and Wilbur M. Scott, Milledgeville.

C. Dan Bowdoin, Atlanta, Director, Division of Venereal Disease Control, Georgia Department of Public Health, was recently presented an honorary

life membership by the American Social Hygiene Association at the annual meeting of the Georgia Social Hygiene Council in Atlanta.

Betty Ann Brooks, Decatur, announces the removal of her office to 603 Church Street, Decatur, for the practice of Obstetrics and Gynecology.

Robert H. Brown, resident in orthopedic surgery at the Warm Springs Foundation recently addressed the Warm Springs Rotary Club.

James H. Byram, Atlanta, was host recently to Dr. Howard B. Carroll, professor of medicine at Northwestern University and Dr. C. H. William Rhue, professor of physiology at the University of Pittsburgh Medical School. The two visiting professors were in Atlanta to address a banquet of the Chi Beta chapter of the Phi Rho Sigma Medical Fraternity at the Atlanta Athletic Club.

Winston E. Burdine, Atlanta, announces the opening of his office, Suite 803 Medical Arts Building, Atlanta, for the practice of psychiatry.

John D. Campbell, Atlanta, is author of a new book, "Manic-Depressive Disease—Clinical and Psychiatric Significance," recently published by J. B. Lippincott & Co.

J. W. Chambers, LaGrange, addressed the Business Girls League of LaGrange on the subject, "Health Education and the Problems of a Civic Health Program."

Ellison R. Cook, III, *C. A. Henderson* and *R. B. Gottschalk*, Savannah, have been named to a committee to formulate plans for the establishment of a local physical medicine and rehabilitation center.

C. H. Dickens, Madison, attended the Annual Post Graduate Tri-State Obstetric and Pediatric Seminar at the Sheraton Plaza Hotel, Daytona Beach, Fla.

Edgar M. Dunstan, Atlanta, presided at a recent meeting of the medical graduates of Emory University at the Dinkler-Plaza Hotel, Atlanta.

Charles Eberhart, Atlanta, and *John Hill* and *Joseph Brannen*, Albany, are co-authors of an article, "The Treatment of Urethritis in Women: A New Etiological Concept," appearing in the October issue of the Southern Medical Journal.

Ernest Edwards, Savannah, recently addressed the women's activities committee of the Chatham-Savannah Polio Chapter on "What Surgery Can Do For Polio Victims."

Robert B. Greenblatt, professor of Endocrinology, Medical College of Georgia, Augusta, appeared as a guest speaker at the recent 24th Annual Scientific Assembly of the Medical Society of the District of Columbia at the Hotel Statler, Washington, D. C. His topic was "Treatment of Menstrual Disorders."

William F. Hamilton, professor of physiology, Medical College of Georgia, Augusta, recently spoke before a meeting of the Augusta Rotary Club.

J. H. Hilsman, Atlanta, announces the removal of his offices to 1211 West Peachtree St., N.E., Atlanta, for the practice of internal medicine (gastroenterology).

Fred G. Hodgson, Atlanta, has been elected president of the Georgia Orthopedic Society. Other new officers include *T. P. Waring*, Savannah, vice president; and *C. G. Henry*, Augusta, secretary-treasurer.

J. F. Hooker, Waycross, presided at the Institute on Diabetes and Cardiovascular Diseases held recently at Waycross. Others taking part included *M. E. Winchester*, Brunswick; *A. M. Knight, Jr.*, Waycross; *H. T. Atkins*, Waycross; *Gordon Barrow*, Atlanta; *J. Gregg Smith*, Valdosta and *Mildred Scott*, Atlanta.

James Hughes and *David F. James*, Atlanta, announce their association for the practice of internal medicine.

Jabez Jones, Savannah, announced his decision to retire from active practice at a testimonial dinner given him recently by the hospital staff of Telfair Hospital, Savannah. He has practiced medicine for 55 years and was medical director at Telfair from 1912 until 1945.

Harold B. Levin, Atlanta, was married recently to Miss Elaine Levine, daughter of Mr. and Mrs. Marc Levine of Birmingham, Ala.

Stewart M. Long, Atlanta, announces the removal of his office to 1107 Medical Arts Building for the practice of general surgery.

William Clyde McGeary, Jr., Madison, was married recently to Miss Eunice Valentine, daughter of Mr. and Mrs. E. C. Valentine, Jacksonville, Fla.

Taking part in the Occupational Health and Rehabilitation Conference in Atlanta recently were *Christopher J. McLoughlin*, *L. Minor Blackford*, *Joe M. Bosworth, Jr.*, *Carl Aven*, *Rives Chalmers*, *M. B. Copeloff*, *T. P. Goodwyn*, *Jeff Richardson*, *C. L. Ridley, Jr.*, *Harry Rogers*, *Richard Wilson* and *Lester M. Petrie*, all of Atlanta.

J. W. Palmer, Ailey, was honored at a dinner in Atlanta recently for 42 years of service on the State Board of Medical Examiners, 50 years as a member of the Medical Association of Georgia and 54 years in the medical profession. *Grady N. Coker*, Canton, and *Alex B. Russell*, Winder, participated in the program.

R. B. Quattlebaum, Fort Gaines, addressed the fall meeting of the PTA on the subject, "The Need for A Public Health Nurse for Clay County."

C. Purcell Roberts, Atlanta, announces the removal of his office to 1211 West Peachtree St., N.E., for the practice of internal medicine and cardiology.

John Calvin Rollins, College Park, and his wife recently celebrated their 50th wedding anniversary.

Albert A. Rosenberg, Atlanta, was recently certified by the American Board of Pediatrics.

Thomas L. Ross, Jr., Macon, was principal speaker at a recent meeting of the Barnesville Rotary Club.

Carter Smith, Atlanta, presided at the Southeastern Regional Meeting of the American College of Physicians at St. Simons Island. Others taking part were Millard E. Winchester, Brunswick; Eugene B. Ferris, Joseph Skobba, D. Henry Poer, Harriet Gillett, Arthur Merrill, George Mitchell, William R. Minnich, Haywood N. Hill, Walter L. Bloom, Joseph H. Hilsman, and A. Park McGinty, all of Atlanta, and Haywood L. Moore, Brunswick.

W. P. Smith, Jr., Newnan, is now practicing surgery in Philadelphia.

Calvin B. Stewart, Carl C. Aven, C. Purcell Rob-

erts and J. G. McDaniel, Atlanta, participated in a panel discussion on station WAGA-TV. The topic was how the Visiting Nurse can serve the patient in the home.

Robert M. Tankesley, Atlanta, presided at a recent meeting of the Georgia-Florida Radiological Society at the King and Prince Hotel, St. Simons Island.

Frank Vinson, Fort Valley, Charles Wills, Jr., Washington, and J. B. Kay, Byron, attended a meeting in Chattanooga of the Tennessee Valley Medical Association.

Neal F. Yeomans, Waycross, attended a two-week course on the use of radioisotopes in medicine at the Oak Ridge Institute of Nuclear Studies.

DEATHS

CARTER: Curtis Braxton, 86, Columbus, a retired eye, ear, nose and throat specialist, died October 6 at his residence, 1545 Third Avenue. A graduate of the University of Georgia and the University of Alabama, Dr. Carter practiced medicine 25 years in New York City before moving back to Columbus in 1916. He was a recipient of the Certificate of Distinction from the Medical Association of Georgia for 50 years in the practice of medicine.

HARDMAN: Charles Terrell, 65, Tallulah Falls, well-known Habersham County physician, died October 4 in Atlanta. A native of Newton County, Dr. Hardman had practiced for a number of years in Tallulah Falls. He also served until June as physician for the Georgia Power Company at Tallulah Falls. He was a steward of the Tallulah Falls Methodist Church and served as chairman of the board of trustees of the Tallulah Falls School.

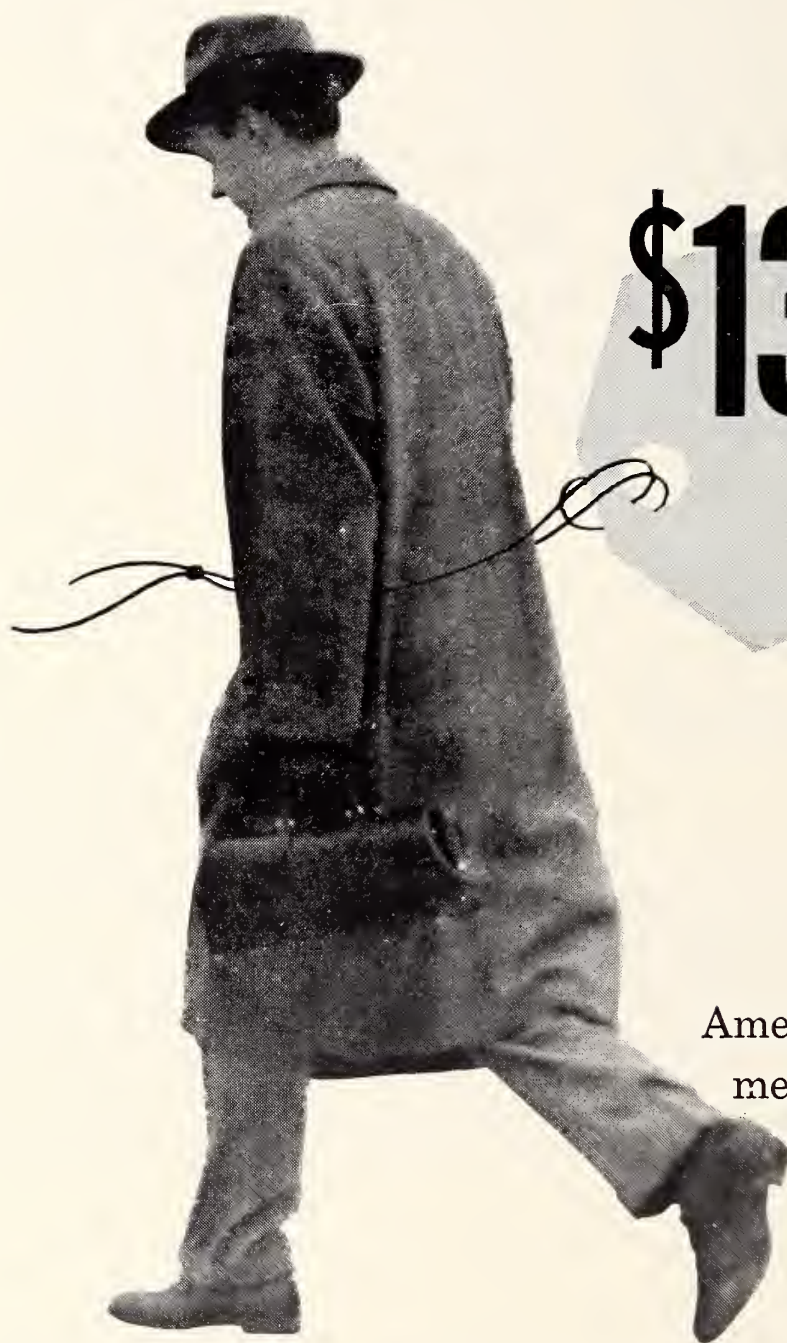
PRICE: William Thomas, 70, Augusta, died September 24 at a hospital in Augusta. He was a graduate of the Medical College of Georgia and served there on the staff. He was a former chairman of the board of stewards of Trinity-On-The-Hill Methodist Church and a member of the Board of Trustees.

MAG Journal Cited

An editorial in the September issue of "The Journal of the Michigan State Medical Society" praises the 1953 format of the JMAG with particular reference to the June and July issues. The editorial states, "The 'Medical Association of Georgia' has recently made a study of its Journal which is now appearing in white, with a square uncolored section containing, in the June number (the Annual Session Proceedings number), a photographic reproduction of part of the Hippocratic oath, overshadowed by a

gavel. This is all very attractive.

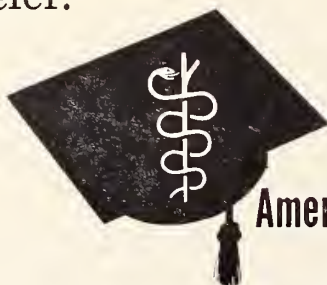
"The July number has the same format, but the white space contains a picture of a father and his young son sitting on the end of a pier, fishing and the motto, 'It is later than you think.' The paper stock is very good, type clear and easily readable, the editorials short and snappy. We are pleased to see another medical journal giving some originality and variety to its cover. Congratulations!"



\$13,356

America's
medical schools graduated
6,135 new doctors
of medicine last year.
It cost \$13,356
to train each of them.

Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.

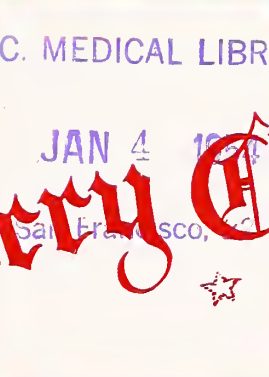
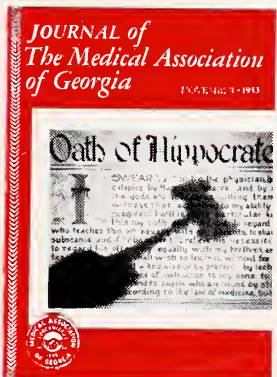
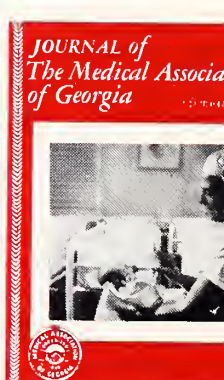
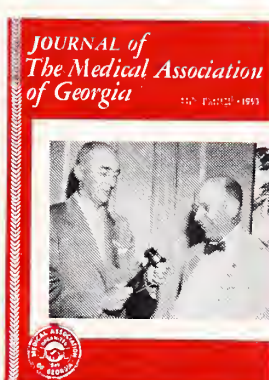
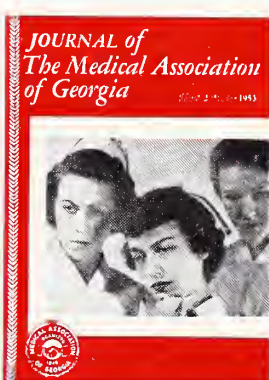
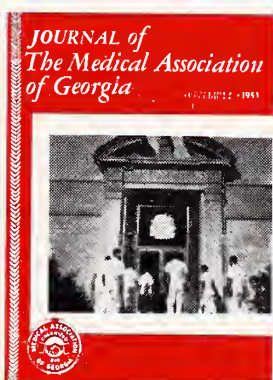
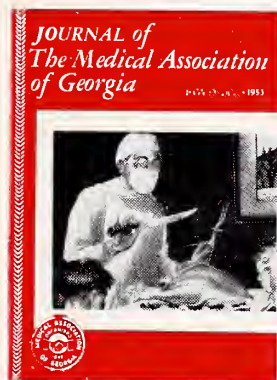


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JOURNAL of The Medical Association of Georgia

DECEMBER • 1953

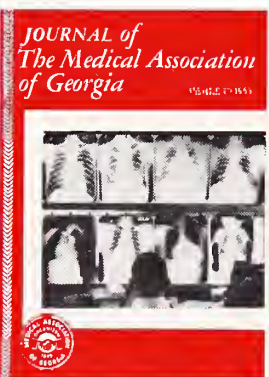
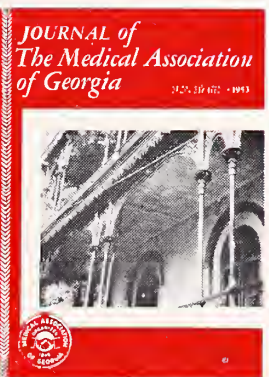
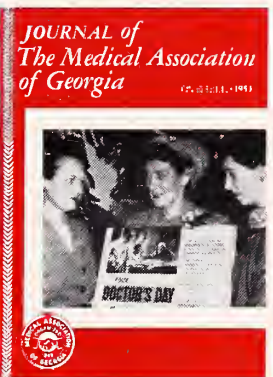
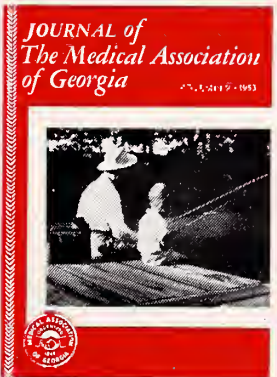


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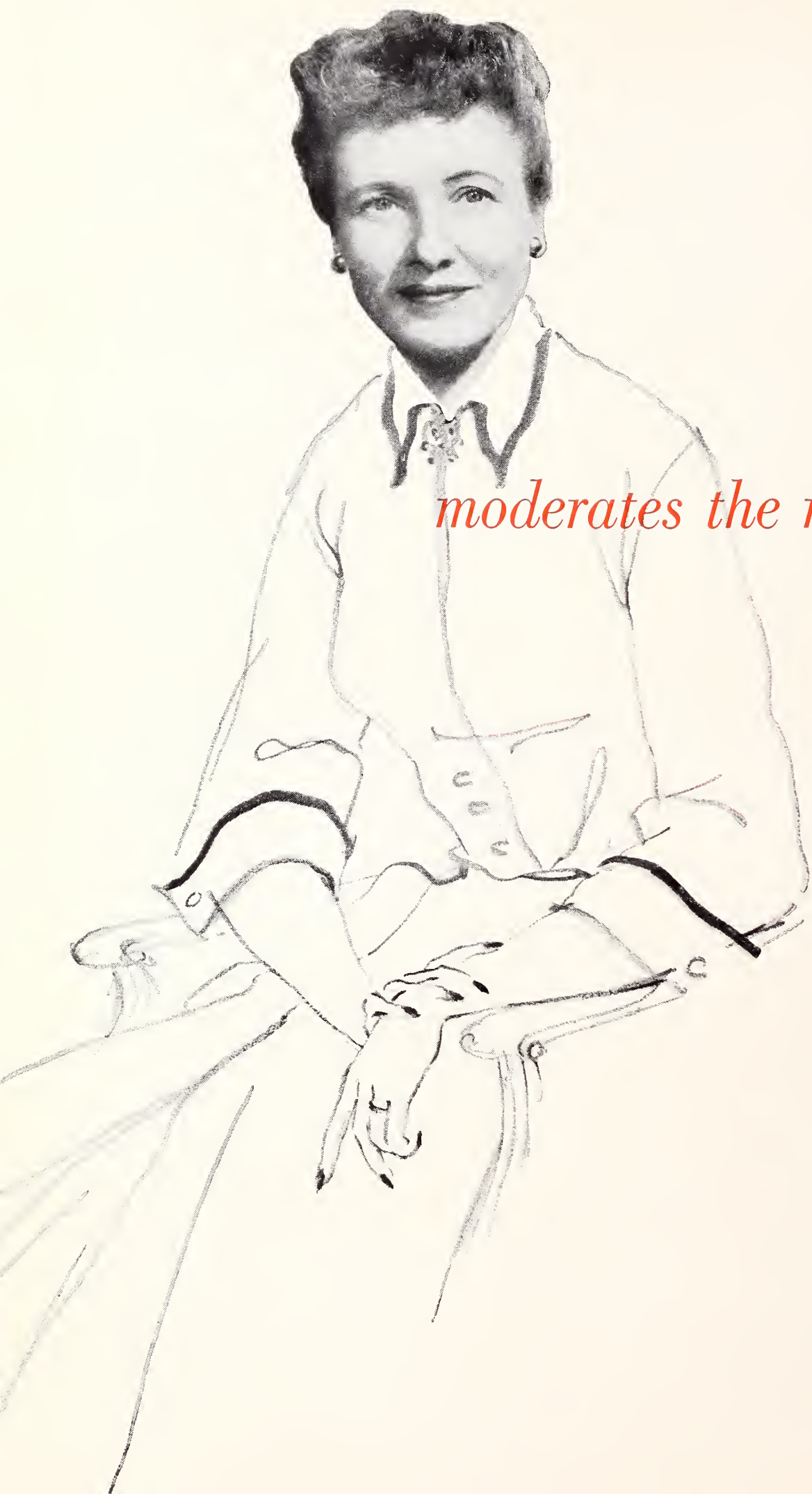
JAN 4 1954

San Francisco, CA

Merry Christmas



Index Issue



moderates the menopause

*The JOURNAL
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OF GEORGIA*

DECEMBER, 1953

VOLUME 42

NUMBER 12

*JOURNAL of
The Medical Association
of Georgia* DECEMBER • 1953



Merry Christmas



Index Issue

Our 1953 *Journal* covers are grouped together to form a Christmas greeting for the December Index Issue. This format marks the first time three colors have ever been used on the cover of the *Journal*. Many thanks to our printer, Franklin Printing & Manufacturing Co., and our photographer, who join with the *Journal* staff in wishing Georgia's physicians a very Merry Christmas.

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MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS

Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS

Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

GENERAL POLICY

The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Georgia.

MEDICAL EDITING SERVICE

If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

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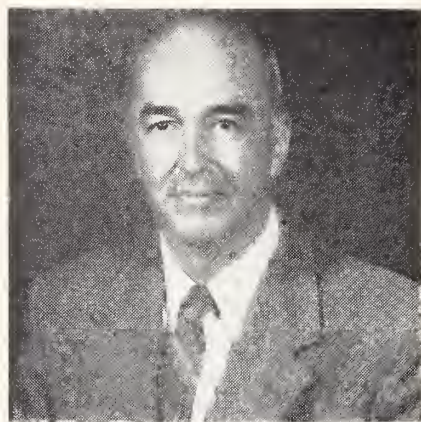
All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1953 by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy.

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president's page



As

the

Christmas

Season approaches,
it is well to pause and
give thanks for the many
things with which we are
blessed. This is the time when
our first consideration is to enjoy
the happiness of our families and
the fellowship of our friends. You
have my best wishes for a
Merry Christmas
and a Happy
New
Year.

WILLIAM
HARBIN

hospital page



Laurens County Hospital Dublin, Georgia

The Laurens County Hospital which has sixty beds was opened for the reception of patients on September

23, 1952. The occupancy rate of this hospital has steadily improved since its opening. Four physicians have located in Dublin to practice medicine since this hospital was opened.



Saint Joseph's Hospital Augusta, Georgia

Saint Joseph's Hospital was opened in Augusta, Georgia on December 29, 1952. This new hospital

provides one hundred and twenty-four additional beds for the Augusta area. The hospital is operated by the Sisters of St. Joseph of Carondelet.



physician's bookshelf

BOOKS RECEIVED

PERIPHERAL NERVE INJURY: By Webb Haymaker, M.D., Chief, Neuropathology Section, Armed Forces Institute of Pathology, Washington, D. C., and Barnes Woodhall, M.D., Professor of Neurosurgery, Duke University School of Medicine, Durham, North Carolina. 2d Edition. Principles of Diagnosis. Published by W. B. Saunders Company, Philadelphia and London. 333 pages, including 272 illustrations. Price \$7.00.

AN ATLAS OF PELVIC OPERATIONS: By Langdon Parsons, M.D., Professor of Gynecology, Boston University School of Medicine, Chief, De-

partment of Gynecology, Massachusetts Memorial Hospital, Gynecologist, Palmer Memorial Hospital, Gynecologist, Massachusetts Department of Public Health, Hospital for Cancer at Pondville, Massachusetts, and Howard Ulfelder, M.D., Assistant Clinical Professor of Gynecology, Harvard Medical School, Assistant Surgeon, Massachusetts General Hospital, Gynecologist, Massachusetts Department of Public Health, Hospital for Cancer at Pondville, Massachusetts. Illustrated by Mildred B. Coddington, A.B., M.A., Surgical Artist, Department of Surgery, Harvard Medical School and Peter Bent Brigham Hospital, Boston, Massachusetts. 231 pages with illustrations. Published by W. B. Saunders Company, Philadelphia and London. Price \$18.00.

REVIEW

SURGERY AND THE ENDOCRINE SYSTEM: By James D. Hardy, M.D., F.A.C.S. This monograph concerning the endocrine system's response to trauma and disease should be of interest and value to students and surgeons. The author has been able to condense and present the voluminous material relative to endocrine function in a simple and interesting manner.

The author has divided this book into two general sections. The introductory portion deals with the surgical patient's response to trauma and general dis-

cussion relative to the role of the endocrines in convalescence. One of the initial chapters is devoted to the current principles of endocrine therapy in surgical patients. The second portion of this volume deals with the function of specific endocrine glands and in a general manner discusses the surgical management of disease processes affecting the endocrine system.

This book provides information that will improve the over all care of the surgical patient by clarifying the way in which certain recent advances in physiology can be utilized in patient management. The bibliography is excellent and provides convenient reference for more detailed discussion of specific problems.

Lierle Presents Equen Memorial Lecture

Dean Lierle, professor of Otolaryngology and Oral Surgery at the University of Iowa delivered the Jonte Equen Memorial Lecture December 3, 1953 at the Academy of Medicine, Atlanta. Dr. Lierle talked on "Oral Lesions." His lecture was illustrated with colored slides.

The Jonte Equen Memorial Lectures were founded in 1936 by Murdock Equen in memory of his father. The lectures were discontinued during the war but were resumed again in 1950. The lecturers speak on subjects in the field of eye, ear, nose and throat.

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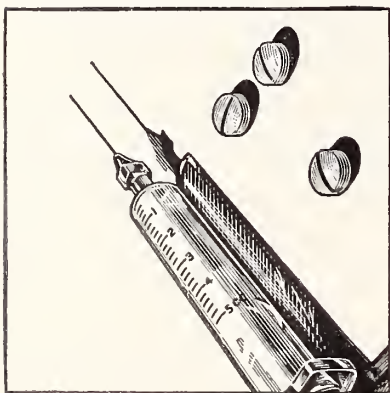
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POTASSIUM



JOURNAL PROGRESS

It is with much pride and satisfaction that we report to you on the progress of your *Journal*. Recently a survey was conducted by the State Journal Advertising Bureau of the American Medical Association in an effort to estimate the scientific quality of original manuscripts and editorial matter in its member Journals. A close correlation between editorial quality and reader interest was established.

This survey was based on the fact that the *JAMA* and other publications periodically examine all other medical journals for "interesting" or "important" articles for publication in abstracted form.

The most widely circulated journals which publish such abstracted articles are the *Journal of the American Medical Association*, *Modern Medicine*, and *Current Medical Digest*. Results from the study revealed the average number of articles contributed

by State medical journals to abstracting sources to be six or one every other issue. We are happy to report that your *JMAG* led the field of state journals throughout the country with a total of seventeen papers abstracted during the past twelve months.

Further evidence of the *Journal's* wide coverage was brought to our attention recently. Within the past year, one of our contributors has received more than ninety thousand requests for reprints from all parts of the country. This unusual response followed the publication of a special article concerning doctors and their retirement problems.

This remarkable improvement in the overall quality of your *Journal* has been made possible only through your continued contribution of superior material for publication. We are confident of even better material for the future.

BETTER *County Society* PROGRAMS

Progress in the medical profession has not been limited to advances in medical therapeutics and new surgical techniques. Medical progress also implies improved standards of medical ethics along with better understanding among physicians. Advances in this area can be facilitated in the future through better organized and more frequent meetings on the county society level.

Formerly, around the turn of the century, there was prevalent a "root-hog-or-die-poor" type of ethics, and postgraduate training was limited to the fortunate few. But now, in this age of rapid advances in medical knowledge, the physician can no longer complete his medical training, hang out his shingle, ignore his fellow physicians and practice medicine the remainder of his life without further training. Few, if any, physicians in present day practice would consider such a plan.

Today, the activities of the county society are considered an important part of the "postgraduate" training of the practicing physician. But, unfortunately, many small societies have been handicapped by their small membership. Scientific programs are held rarely or not at all. The members have been unable to attract well-trained speakers. To combat these disadvantages in size, several small county so-

cieties have joined together to form larger and better organized groups. Examples include the Randolph-Terrell, and Cherokee-Pickens Societies.

An objection to this scheme has been raised. It is maintained that the small county loses its identity and representation at the state convention when it merges with another society. For this reason several county societies are holding joint scientific meetings and retaining the integrity of their individual societies through separate business meetings.

Stephens and Habersham County Medical Societies are following this plan. Joint scientific meetings, alternating between Toccoa and Cornelia, are held by the two societies. Separate business meetings are held.

The hope of the medical profession today lies in the maintenance of a solid front against government administered medicine. This can only be assured by a unity of purpose among its individual members. It is felt that joint scientific meetings between small societies will promote better understanding between small, widely scattered groups and can make available to these groups more qualified speakers. The plan is recommended to other small county societies in Georgia.

GEORGE T. NICHOLSON, M.D.

FRANK K. BOLAND

Franks Kells Boland, a leading figure in the field of surgery for half a century, died November 11. Born of Atlanta parents in Indianapolis in 1875, he grew up in Atlanta, attended the University of Georgia, graduating in the class of 1897. He entered the Atlanta College of Physicians and Surgeons and graduated in 1900. Later he studied at Johns Hopkins in Baltimore.

Frank Boland was active in the practice of surgery and teaching medical students. When the United States became involved in World War I he went abroad with the Emory Unit and was chief of the surgical section. After the war he re-entered the practice of surgery in Atlanta. He was head of the department of surgery of Emory Medical School from 1921 until 1930.

Doctor Boland was active in many leading medical and surgical societies. He served as president of the Fulton County Medical Society, The Southeastern Surgical Congress, The Medical Association of Georgia, The Emory Alumni Association and the University of Georgia Alumni Association. He was a fellow of the American College of Surgeons, The American Surgical Association, a member of the American Association for Thoracic Surgery, The American Association for Traumatic Surgery and a member of the Societe, Internationale de Chirurgie.

During his medical career Doctor Boland became intensely interested in the history of anesthesia. It was through his research and efforts that recognition

of Dr. Crawford W. Long as the discoverer of ether anesthesia was achieved. A result of these efforts was a statue of Doctor Long in the Hall of Fame. Following the authentication of Crawford Long's triumph, Doctor Boland wrote a book called "The First Anesthetic" which was published in 1950.

In spite of his very busy practice, Doctor Boland was active on civic and fraternal organizations. He served as president of the Atlanta Historical Society, The Crawford W. Long Memorial Association, Chairman of the Atlanta Chapter of the American Red Cross and of the English Speaking union. Doctor Boland was a member of the Chi Phi fraternity, Phi Beta Kappa, Phi Chi, Omicron Delta Kappa, the Atlanta Rotary Club and the Trinity Methodist Church.

In the passing of this great medical leader and teacher of surgery, Georgia and the South has lost one of its outstanding citizens. Dr. Frank Boland, until the last, was always ready to serve his patients and all

who called upon him for help. He never turned down a call even at night and it is truly said that the spirit of service above self exemplified the man whose death will be mourned by all who knew him.

Doctor Boland is survived by his wife, the former Mollie Horsley, and two doctor sons, Frank Kells, Jr. and Joseph H. Boland, both of Atlanta, and a sister Miss Amy Boland of Atlanta, and four grandchildren.

HAROLD P. McDONALD, M.D.



Dr. Frank Kells Boland

ABSTRACT SECTION

With this issue the *Journal* inaugurates a new feature: a section on abstracts by Georgia authors. Readers throughout the state have expressed desire for such a service. Comments and criticism of this new feature are solicited.

More than one hundred leading journals are reviewed by our staff at monthly intervals. By this method a maximum period of two months is allowed to elapse between the original article and the *JMAG* abstract. Authors are contacted and invited to sub-

mit abstracts before the fifteenth of the month following their original publication. During the month just past, twenty papers by Georgia authors were published in medical journals outside the state. These authors responded well to our requests. Evidence of their interest and kind cooperation is amply demonstrated in the abstract section of the current issue.

No longer need a prophet remain without honor in his own country.

SYDNEY JACOBS, M.D.;
ALAN J. LEONARD, M.D. and
ISADORE YAGER, M.D., New Orleans

DIABETES *and* TUBERCULOSIS

"Modhumelia (honey-urine) is a disease which the rich principally suffer from and is brought on by their own over-indulgence in rice, flour and sugar. The patient feels weak and emaciated and complains of frequent micturition, thirst and prostration. Ants flock around his urine. Carbuncles and phthisis are its frequent complications."

This quotation from the Ayur Veda of Susruta,² published in the year 600 A.D., suggests that even the ancient Hindus were aware that diabetes mellitus predisposes to pulmonary tuberculosis. Many statistical studies indicate that tuberculosis follows diabetes because of some relationship between the two diseases and not by chance. Accordingly, tuberculosis is to be regarded as a complication of diabetes, in many respects more like vascular than suppurative states.

As a rule, shortly after it begins, the tuberculosis advances rapidly and seldom undergoes spontaneous resolution. The clinician is apt to see the patient first with fully developed caseous pneumonia. (Case I, Fig. 1)

CASE I

A.S., 62 year old white widow had been treated successfully for diabetes for 10 years until the onset of what was regarded as a right basal pneumonia. A previous film (made 2 years earlier) was entirely normal. The area of consolidation extended, became caseous and excavated simultaneous with the demonstration of acid fast bacilli in the sputum. It is of interest that several members of her family had diabetes and died of tuberculosis.

Although the combination may occur at any time of life, it is much more frequently seen in diabetics during middle age. The severity of the diabetes and the severity of the tuberculosis seem to be entirely independent of one other. With a suitable diet and sufficient insulin the diabetes may be controlled, but the outlook for the pulmonary tuberculosis is poor.

Frequency of Co-Existence

How frequently does tuberculosis complicate diabetes? Adams¹ observed 1 per cent of diabetics to have tuberculosis while Sossman⁹ and Stiedl found



Figure 1

9 per cent of diabetics with tuberculosis. Boucot and Cooper³ examined 3,106 diabetics and found 8.4 per cent to have tuberculosis. For comparison they studied photorentgenograms of 71,767 apparently healthy industrial workers of similar age, race and sex and detected only 4.3 per cent with tuberculosis. Obviously if one wishes to find cases of tuberculosis, he should make a survey of diabetics.

The association of these two diseases will probably be more frequent because of the increasing number of diabetics whose life span has been prolonged by adequate therapy, and who will now live sufficiently long to develop tuberculosis. We do not actually know why diabetics are peculiarly liable to develop tuberculosis. An explanation offered¹⁰ previously was in effect that diabetics lack natural resistance to the tubercule bacillus. This is a statement which cannot go unchallenged. Diabetes mellitus is most severe when it appears early in childhood; yet tuberculosis is seldom seen in children who may have had several bouts of acidosis.

We are reporting in this paper on 55 well-studied cases of diabetes with co-existent tuberculosis, and have examined the records of at least 100 other such patients (not included in the present tabulation). Tuberculosis did not develop before the age of fifteen years in any of these cases. In a separate study of 20 juveniles for periods of 1 to 10 years after the development of diabetes, no case was found to have

From the Department of Medicine, Tulane University School of Medicine and the Charity Hospital of Louisiana at New Orleans, La.

Read before the Georgia Trudeau Society, Medical Association of Georgia Annual Session, Savannah, Ga., May 13, 1953.

tuberculosis, although several were the children of tuberculous parents, while others had been treated for multiple bouts of acidosis and coma. Indeed, in such severely diabetic patients, the onset of tuberculous infection should have progressed rapidly if the only significant factor was lack of resistance to the mycobacterium tuberculosis.

Boucot and Cooper found more active tuberculosis in diabetics under the age of 40 than over the age of 40 (5.3 per cent against 1.7 per cent). Wiener and Kavee¹¹ found only 18.8 per cent of diabetics with tuberculosis under the age of 40. They found more tuberculosis when the diabetes lasted as long as ten years, especially in those under the age of 40. Diabetic patients seem to develop tuberculosis later in life than those without diabetes. The reason for this is not apparent. There may be other factors than disturbed carbohydrate metabolism responsible for this phenomenon. As the accompanying chart indicates (Fig. 2) in Louisiana the age of onset of tuberculosis in 1952 reached a peak in the age group 25 to 34 years, whereas the onset of tuberculosis among diabetics reached a plateau between the age of 35 and 55.

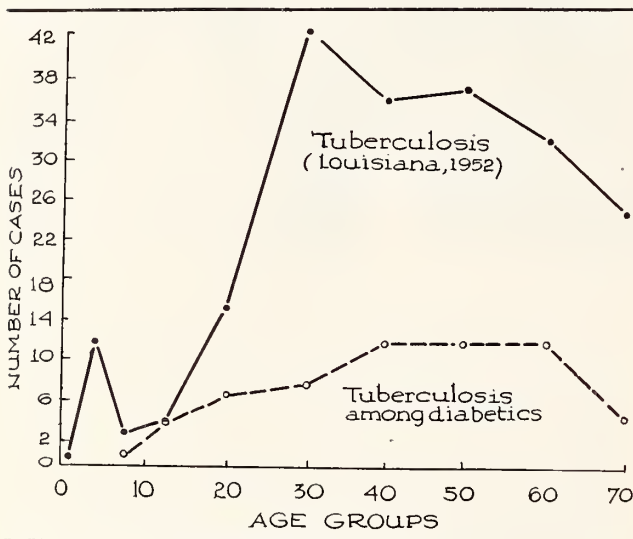


Figure 2.

If a tuberculous patient develops diabetes, his new disease is essentially like the diabetes of the non-tuberculous patient as the following case indicates.

CASE II

T.J., a 27 year old white man, reported for treatment 2-15-40 because a moderately advanced lesion had been found in the middle third of the right lung, and acid-fast bacilli had been demonstrated in the sputum. Artificial pneumothorax was started 3-14-40 and maintained uneventfully for four years, at the end of which time complete re-expansion occurred. All examinations of the sputum were negative for acid-fast bacilli by culture, and the patient reached the stage then termed "apparently cured." He was not seen again until 2-8-49 when he was in diabetic acidosis. With appropriate therapy for the diabetes, all symptoms disappeared and he regained his accustomed vigor. He was seen irregularly subsequently, and has not adhered to the diet but has taken 40 units of globin insulin daily. Despite this poor control of his diabetes, there has been no physical roentgenological or bacteriological evidence of reactivation of the tuberculosis.

The frequency of diabetes complicating tubercu-

losis is no greater than in the population at large. In our series of 55 patients with the two diseases, tuberculosis began first in only three. These patients were ages 34, 42 and 69 years respectively. Their diabetes was no more severe nor more difficult to control than is diabetes generally and as far as we have been able to determine, the development of diabetes did not materially influence the course of their tuberculous lesion.

Severity and Control

Determining the severity of diabetes causes much confusion. Many authors estimate the severity of diabetes by the amount of insulin a patient requires. We do not believe this to be adequate. Varying dietary patterns, fluctuations in pancreatic secretion in response to greater or lesser degrees of tuberculous toxemia, the multiplicity of factors affecting the daily life of the tuberculous patient all combine to produce great instability in the daily insulin requirement. We have been impressed by the fact that our patients could be termed "labile," in that the amount of insulin required changed so frequently and so drastically. It does not seem proper to regard this as a change in "severity," although it could be termed a change in the degree of control. We have noted that many authors have classified their cases as severe, moderate or mild but that few, if any, have defined severity. In an attempt to establish for our own use the meaning of severity, we concluded that the severity of diabetes has to do with its rapidity of progression to fatal termination by acidosis, vascular complication or infection. Stated otherwise, the severity of diabetes is inversely proportionate to the length of life of the individual after development of diabetes. Obviously this prognostic element makes it far from a satisfactory definition; one, by these terms, cannot measure the severity so long as the patient lives. With these reservations, we devised an arbitrary formula for the estimation of severity. By means of our formula, we concluded that seven of our patients had severe, 38 moderately severe, and 11 had mild diabetes.

It is our impression that control and severity are independent, although related, phenomena. The control of diabetes signifies the degree to which an individual, at any given time, is protected by proper therapy against the physio-chemical imbalances of diabetes. Several factors were helpful in determining whether good diabetic control had actually helped protect our patients against the physio-chemical imbalances of diabetes. It was found that 7 were well controlled, 10 were in fair control and 48 were poorly controlled. Apparently, the final outcome of tuberculosis did not depend on the severity of the diabetes, but did depend to a great extent on the control of the diabetes. Unquestionably with better control of diabetes, as in any other infectious state, there is a greater tendency for tuberculosis to heal within limitations. While lack of control of the diabetes almost always was attended by exacerbation of the tuberculosis, excellent diabetic control by no means insured arrest of the tuberculosis. That most of our patients were poorly controlled, reflects their social and

economic circumstances. Joslin⁷ pointed out that all Quarter Century Victory Medal winners (juvenile diabetics who had no obvious complications after diabetes for 25 years) enjoyed unusually favored circumstances. Those whose social and economic circumstances permit them to take good care of their diabetes will probably escape the ravages of tuberculosis as well as vascular complications.

Bucot and Cooper,³ using insulin requirement as an index of the severity of diabetes, found many more instances of tuberculosis among severe diabetics. It is questionable whether their diabetics were actually more severe, or were poorly controlled.

Prognosis

Tuberculosis that develops in a diabetic is extremely grave. The age of onset is that of the diabetes rather than that of the tuberculosis, and the length of life after tuberculosis begins is limited. The average patient in our series lived only eight years from the time of onset of diabetes and only four years from the time of onset of tuberculosis. Although the severity of the diabetes was not marked, the loss of control was extreme. We were further impressed by the finding that once tuberculosis was initiated in the diabetic, its course was rapid despite establishment of good control of the diabetes. Proper adjustment of the diet, adequate insulin and electrolyte replacement prevented acidosis but did not retard progression of tuberculosis. Bucot and Cooper³ found 63 per cent of their survey suspects to have minimal tuberculosis in contrast with 74 per cent of their survey non-diabetics. They also found more basal than apical lesions in the older age groups. Our patients were largely those who had far advanced pulmonary tuberculosis at the time first seen in the hospital. They were not survey subjects but were actually patients who came to the hospital because of treatment, usually for their diabetes, occasionally for their tuberculosis. Suffice it to state, that when the combination of the two diseases causes sufficient symptoms to bring a patient to the hospital, the tuberculosis is no longer minimal but is already far advanced.

How long does a tuberculous lesion in a diabetic take to progress to a fatal termination? At the time of admission to the hospital, all of our patients had far advanced tuberculosis; in the average only about four years elapsed between the appearance of diabetes and the onset of tuberculosis. The life expectancy averaged 3.5 years after the development of tuberculosis. N. Stanley Lincoln⁸ noticed that the nondiabetic patient with a minimal pulmonary lesion had on the average about a 90 per cent chance (95-70 per cent) that his lesion would be inactive three years after the time of the original examination. It is our impression that practically all of our patients who had diabetes had advanced active tuberculosis within three years after diagnosis of the disease no matter how minimal it was in the beginning. It is our impression that the diabetic patient who develops a minimal tuberculous lesion seldom, if ever, undergoes spontaneous regression, and seldom,

if ever, has spontaneous arrest at the minimal stage with fibrosis and calcification. Few of our patients lived sufficiently long to suffer the vascular complications of diabetes. It will be interesting in the course of the next several years to observe patients successfully treated with chemotherapy and surgical measures and to determine whether arrest of their tuberculosis will be followed by the appearance of vascular complications of diabetes. Several of our patients had massive hemoptyses. Only one died of diabetes or its complications (insulin overdoseage). All other fatalities were the direct result of tuberculosis.

Therapy

Prior to the advent of antibiotics, no form of therapy was actually successful for the treatment of tuberculosis in the diabetic. Although pneumothorax was formerly considered an excellent treatment for the diabetic with tuberculosis (some authors¹¹ believing this form of collapse to be the only means of controlling the disease), our impression is that pneumothorax may assist a patient in achieving a temporary arrest in the progress of his tuberculosis. Unfortunately this arrest is only temporary. We have not seen a single patient brought to the stage of inactivity by pneumothorax alone. We do have one patient whose tuberculosis was inactivated following the use of antibiotics and pneumothorax. We have been unable to discover any followup studies in the literature which would indicate how long such pneumothorax treated patients continued to do well, or whether they ever reached the stage of inactivity.

Our experiences with pneumoperitoneum and with thoracoplasty have also proven unsatisfactory. The advent of antibiotics in the treatment of tuberculosis has opened new vistas for the diabetic as well as for the nondiabetic. Our antibiotic-treated patients have lived as long as or longer than all those treated in the pre-antibiotic era. Possibly the tuberculous patient with diabetes should be treated the same as the nondiabetic tuberculous patient with a caseous pneumonia.⁴ Antibiotics should be administered over a period of months until the tuberculosis reaches a chronic phase. Following this, collapse or excisional therapy offer as much promise as in the nondiabetic patient. This is necessarily a preliminary impression. We have not determined whether such diabetic patients will relapse following surgery more frequently than nondiabetic patients. Only time will tell.

We have been impressed that the great majority of our patients who did poorly, were those who exhibited erratic behavior. Many of these were more resentful than the usual diabetic or tuberculous patient of the restriction imposed by both diseases. In view of the importance of control of the diabetes as a determining factor in the development of tuberculosis, we are particularly impressed by the observation of Hinkle and Wolfe⁶ who found that fluctuations of blood sugar in labile diabetics occurred most frequently during periods of stress or strain. Fabrykant's⁵ demonstration of electro-cerebral dysfunction in labile diabetics has stimulated us to study electroencephalographic patterns in our patients.

Summary and Conclusions

1. Diabetes mellitus may be complicated by pulmonary tuberculosis in 1-9 per cent of instances. Ordinarily, it is the poorly controlled and not necessarily the severe diabetic who becomes tuberculous.

2. Tuberculosis occurs later in life than in the non-diabetic, usually progresses more rapidly to a fatal termination and seldom undergoes spontaneous arrest.

3. The average patient in this series lived 8 years after the onset of diabetes and 4 years following the appearance of tuberculosis.

4. Without antibiotics, there is small chance of inactivating tuberculosis, no matter what forms of therapy are used.

5. With streptomycin, para-amino-salicylic acid and isonicotinic acid hydrazide, it is possible to reach the chronic phase of tuberculosis and thereby facilitate current excisional and collapse procedures.

6. Abnormal patterns of behavior may in some fundamental manner be related to the tendency of certain poorly controlled diabetics to contract tuberculosis.

508 Medical Arts Building

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Why Buy Christmas Seals?

There are over 10,000 known cases of tuberculosis in Georgia today. About 1,800 of these people are in Battey State Hospital at Rome. There is a 50 bed hospital in Columbus and one in Savannah. But in Atlanta, the area that has the greatest concentration of cases of tuberculosis in the State of Georgia, there is no tuberculosis hospital. Atlanta patients must go to Battey State Hospital and often must remain on a waiting list until the hospital has room to admit them.

Four hundred and sixty-seven Georgians died of tuberculosis last year. That means that every day, one or more persons dies of TB in our State.

The Atlanta Tuberculosis Association is affiliated with the Georgia State and National Tuberculosis Associations. It is one of 3,000 local tuberculosis associations in the United States and her territories. All these tuberculosis associations work the year round fighting TB under the banner of the red double-barred cross, which appears each year on the Christmas Seals you receive in the mail. The funds

from this annual sale of Christmas Seals provides the money to carry on the tuberculosis fight all year in your community.



Buy Christmas Seals

ROENTGENOLOGIC

Considerations of

GASTRO-INTESTINAL *Bleeding*

ROBERT D. MORETON, M.D., Fort Worth

Bleeding may occur from any portion of the gastro-intestinal tract. The physician will try to determine the probable source from the history, physical signs, results of clinical tests and innumerable indices compiled from experience. Often he can determine the cause of bleeding with exceeding accuracy, but the diagnosis is not complete without confirmation from roentgenologic examination.

The attending physician realizes that certain portions of the intestinal tract are more likely sites for hemorrhage. Usually attention is focused on the stomach. His first impression is usually peptic ulcer. This is logical since peptic ulcer is known to be a common source of bleeding. The patient is then usually referred for study of the upper gastro-intestinal tract.

The radiologist, realizing that he has a patient with gastro-intestinal hemorrhage, must not only search for the peptic ulcer, but also examine each adjacent organ with equal care remembering that other symptoms may be masked.

With this procedure in mind, I would like to demonstrate some of the less common lesions which may cause gastro-intestinal bleeding. We must consider and seek out not only the common causes of the symptom but the more unusual ones, because with the individual patient, statistics are of only relative value.

In many instances the radiologist must employ every method at his command to demonstrate the pathology, realizing that in some 10 to 12 per cent of patients the cause cannot be found even with careful surgical exploration. The radiologist's primary tool is roentgenoscopy, which consists of proper adaptation of the eyes and careful visualization as the contrast medium goes through. The roentgenoscopy is enhanced by palpation, multiple positions, spot films and finally, roentgenograms, not for a diagnosis, but to confirm and document what has been seen.

When the esophagus is examined, one first consid-

ers varices as a cause for bleeding. The presence of new growths must also be considered. Benign lesions of the esophagus are extremely rare. Carcinoma is not as rare, and occurs more frequently in men. It produces a similar picture as noted in other portions of the canal. However, the carcinoma involves a relatively short segment of the tube and may be polypoid (Figure 1) or encircling. It extends laterally through the wall into the mediastinum and may perforate the lung itself, producing a large abscess.

A rare lesion of the esophagus is lymphosarcoma. It begins in the submucosa and produces bleeding only after ulceration. Dilatation of the esophagus proximal to a benign lesion is common. Dilatation above carcinoma is unusual because the rapid course of the malignancy does not allow sufficient time.

In examining the stomach, one always considers the possibility of a hiatal hernia. In the differential diagnosis of this condition we must consider one of three conditions:

(1) The phrenic ampulla which is a normal or functional condition of no clinical significance.

(2) The short esophagus type of hernia which is the result of incomplete embryologic development is not a true hernia of a once normally placed organ. Peptic ulceration is a fairly common complication at the junction of the esophagus and thoracic stomach.

(3) Para-esophageal hiatal hernia is a true hernia of a once normally placed organ and is amenable to surgical repair. Peptic ulceration of the herniated portion of the stomach is a moderately common complication of this type of hernia.

The presence of gastric varices should be considered. Evans points out that they have received much less attention in the literature than their esophageal counterparts. They usually coexist in chronic hypertension of the portal system. Phemester and Humphreys state that under certain conditions the gastric component may provide a greater danger of hemorrhage than the esophageal. They attribute the lack of emphasis on gastric hemorrhage associated with gastroesophageal varices to the fact that bleeding may occur without gross erosions. Hare points out that

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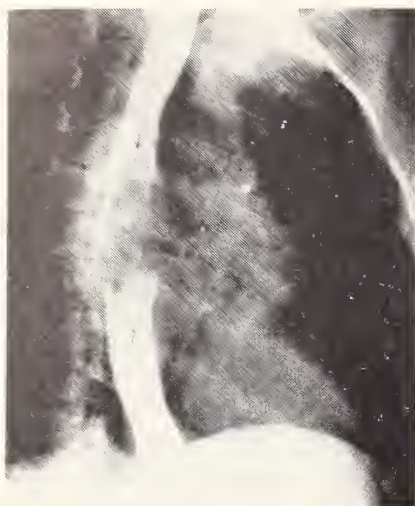


Figure 1. Palypoid carcinoma involving the middle 1/3 of esophagus. Note normal esophagus begins abruptly above and below the lesion.



Figure 2. Filling defect in cardia of stomach produced by carcinoma.



Figure 3. Diverticulum of stomach. Patient had ulcer symptoms with bleeding. Two examinations two months apart were negative except for diverticulum. Patient has been symptom free since removal eighteen months ago.

grouping of the lesions about the esophageal orifice is more suggestive of varices than of carcinoma when there is no evidence of obstruction or involvement of the abdominal portion of the esophagus and when there is present an enlarged spleen which often compresses the lateral aspect of the stomach. Gastric varices should be included among the possible causes of filling defects of the cardia (Figure 2) of the stomach.

Diverticula of the stomach are uncommon but may be present. Bralow and Spellburg report an incidence of 0.02 to 2.6 per cent. There is a broad peak age incidence at 30 to 50 years. The signs and symptoms are not characteristic and diagnosis is usually made by roentgenography or gastroscopy. Moses states that in about 30 per cent of the cases there is present other gastroduodenal disease which produces symptoms. In about a third, the symptoms are due to the diverticulum itself. These may be pain, vomiting and hemorrhage of incapacitating character. The diverticulum (Figure 3) is generally found on the posterior wall near the lesser curvature in the cardia. Ulceration may occur and produce the above symptoms.

Gastric ulcer is the most frequent stomach lesion producing gastro-intestinal bleeding. Sometimes it may co-exist with a duodenal ulcer. At other times it may be difficult to demonstrate; it is shown best by double contrast technique as emphasized by Gianturco. We know quite well its characteristics, symptoms and the necessity of differentiation of benignancy from malignancy.

Gastric polyps should be searched for. They may be entirely asymptomatic. Yarnis, Marshak and Friedman, in reviewing 103 cases, report that bleeding and abdominal pain were the most prominent complaints. Gastric polyps are relatively rare as only 30 were found in 8,735 routine autopsies. They may be single, but are frequently multiple and peristalsis

passes clearly through the area of tumor. Displacement of the defect may be produced by manipulation or change in position. Polypi of the antrum occasionally prolapse through the pylorus into the duodenal bulb and give a filling defect there. Because of their comparative lack of symptoms and absence of physical findings, these tumors are rarely diagnosed clinically. They may occur at any age and should be demonstrated by careful roentgenoscopy.



Figure 4. Leiomyoma of stomach weighing five and one-half pounds on removal. Presenting symptom in emergency room was hematemesis.

Other benign tumors of the stomach must also be considered as they occasionally cause hematemesis and tarry stools by ulceration of the overlying gastric mucosa. Such a tumor is leiomyoma. It is distinguished by intraluminal translucent areas, which are usually well rounded and do not cause interruption of gastric peristalsis. Their presence may be obscured when too much barium is introduced into the stomach. Because of their clinically silent nature, many escape detection during life, and their exact frequency is questionable. The size of these tumors varies greatly, ranging in our series from two and a half centimeters in size to a weight of five and a half pounds (Figure 4) at the time of removal.

Carcinoma of the stomach (Figure 5) is the second most frequent lesion of the stomach to cause gastro-intestinal bleeding. Histologic variations affect the factors of tumefaction and ulceration. Advanced mucoid cancer appears as a gross mass projecting from a wide base far into the gastric lumen. As a rule the tumor is pitted with multiple, ulcerous excavations and occasionally it may be largely destroyed by ulceration. Diminution of the gastric capacity is a common feature of scirrhus cancer resulting not so much from intrusion of the tumor as from shrinkage, shortening and loss of elasticity of the affected segment. Ulceration is constant, but most often shallow and the surface of the growth is usually smooth.

Sarcomas also involve the stomach but are much less frequent. Of these the lymphosarcoma (Figure 6) is the most frequent and may cause bleeding by ulceration. Roentgenologic findings vary widely because of the pathology of this condition. Lymphosarcoma originates in the submucosa and invades in each direction, involving, on the one hand, the mucosa and, on the other, the muscularis of the bowel. Grossly it may produce an intrinsic, extrinsic or infiltrating type of lesion. Manifestations vary

clinically, depending on the type present. Ulceration, though not infrequent, is sometimes absent. When it does occur it is thought to be due to necrosis from pressure and loss of blood supply rather than malignant invasion proper. For these reasons the roentgenologic findings are deceptive and this condition is reported variously as: (1) negative in cases of early involvement; (2) gastric ulcers which resemble simple benign peptic ulcers and may be on either the lesser or greater curvature; (3) Diffuse infiltration of the entire stomach with or without peristaltic movement, depending on the amount of involvement of the muscularis; (4) Polypoid lesions indistinguishable from carcinoma; or simply as (5) Obstructing lesions at the pyloric end of the stomach, type undetermined. Holmes, Dresser and Camp point out that the possibility of this disease should be considered in all atypical cases showing carcinoma-like deformities.

When the mucosal folds of the stomach are redundant and peristalsis pushes them through the pylorus, there is a filling defect observed, designated as prolapse of the gastric mucosa. Archer points out that this may cause gastro-intestinal bleeding due to pressure of the pyloric sphincter which in turn causes congestion and secondary ulceration within the mucosa. If this bleeding is insidious it is usually confined to the bowel and may give an anemia which would suggest a lesion of the right colon. When, however, the bleeding is profuse it may cause hematemesis.

If the patient's stomach has previously been resected, we must consider the presence of a recurrent or jejunal ulcer. Here, as in other examinations of the gastro-intestinal tract, roentgenoscopy is of prime importance. Most of the craters lie within the wall of the jejunum opposite the stoma or in efferent loops within three centimeters of the stoma. They have the characteristics of other ulcers and may vary from a few millimeters to two or three centimeters in diameter.

As we all realize, duodenal ulcer is the most fre-

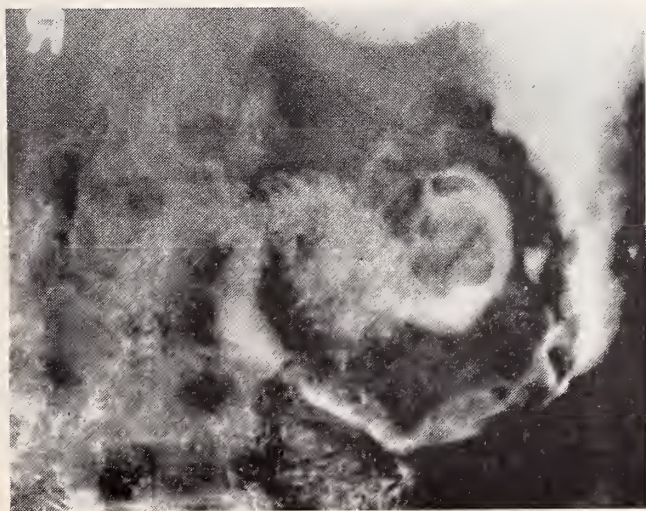


Figure 5. Large ulcerating carcinoma of stomach in patient having hematemesis and dark stools. Pathologically this was a metastatic carcinoma from the uterus.



Figure 6. Large polypoid carcinoma-like lesion of the stomach proven to be a lymphosarcoma.

quent cause of gastro-intestinal bleeding. Since about three-fourths are readily demonstrated by means of the opaque meal and roentgen ray, the impression is held by many that the diagnosis is not only easy, but that, in the absence of readily elicited and conspicuous bulbar deformity, duodenal ulcer can be excluded. The remaining one fourth, which to some degree are difficult to demonstrate, are easily overlooked if the above criteria is considered.

Tumors of the duodenum may cause gradual bleeding by bowel or hematemesis. They produce the same type of defect as found in other portions of the gastro-intestinal tract. The tumefactive lesion may be described as polypoid as in the case of the intra-luminal polyps: marginal, as is noted in carcinoma about the ampulla of Vater, producing a so-called reverse three deformity; or encircling, as in carcinoma of other portions, causing an abrupt defect which is usually short. These tumors may cause a partial or complete obstruction depending on the extent of their involvement at the time of discovery.

If the cause of bleeding is not found, the radiologist should carefully examine the small bowel. This calls for frequent painstaking fluoroscopy and roentgenograms. The small tumors (Figure 7A) are best demonstrated by spot films (Figure 7B) in many instances and at times may not be seen at all on the routine roentgenogram. Also, inflammatory lesions may be encountered which cause ulceration of the mucosa.

Another lesion occurring in the distal five feet of the ileum is Meckel's diverticulum. This is a developmental anomaly occurring in about two per cent of the population with males predominating in a ratio of 2:1. Very few successful attempts at demonstrating Meckel's diverticulum by roentgenologic methods have been recorded. They may be found both by examination of the small bowel, (Figure 8) giving barium by mouth, or by using double contrast studies of the colon and terminal

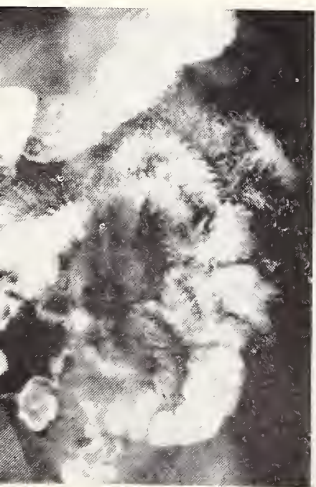


Figure 7-A. Polypoid tumor of the ileum—Proven to be an adenoma.

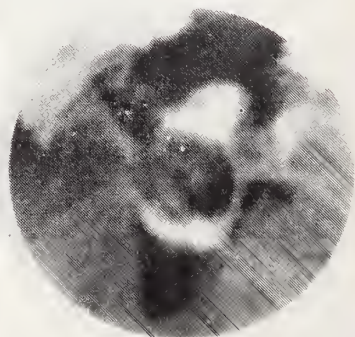


Figure 7-B. Spot film showing pedicle and detail of intraluminal small bowel tumor. Symptom was "farry staals."



Figure 8. Meckel's Diverticulum demonstrated on regular small bowel examination.

ileum. The mucosa lining this anomalous pouch may become diseased and ulcerate, causing hemorrhage. Weber points out that the roentgenologist assists in the diagnosis of Meckel's diverticulum in two ways: (1) by actual demonstration of the diverticulum somewhere in the distal 150 centimeters of the ileum; (2) failing this, by assisting in the exclusion of other intestinal lesions as causes of symptoms.

Bleeding lesions of the colon are relatively frequent in comparison with the remainder of the gastro-intestinal tract, and as in the esophagus and stomach, we are much more sure of our diagnosis than in the small bowel. This is primarily because of our ability to more adequately control our examination, regardless of the method used and lack of multiple overlying loops which may add to the confusion.

Diverticula of the colon are considered a source of bleeding by several outstanding gastro-intestinal radiologists, whom I consulted during the preparation of this paper. They are not the most likely causes of this symptom, and other pathology should be ruled out (Figure 9A and B) in each instance. They occur in about 5 per cent of all persons over 40 years of age, are usually few in number, sparsely distributed and are not usually inflamed. Occasionally, one or more diverticula become inflamed, producing the entity designated as diverticulitis. It occurs almost always in the sigmoid, causing the patient to complain of marked tenderness over the region.

Chronic ulcerative disease is also a source of bleeding. The color of the blood and its consistency will depend on the location of the lesion in the bowel, as well as the acuteness of the disease process.

This may refer to one of several etiological types of intestinal disease. Of differential diagnostic significance are such recognizable features as the site of apparent earliest and severest involvement, the direction of extension, the general intensity of the disease and the roentgen findings in other organs. Roentgen changes in thrombo-ulcerative colitis are usually more intense than in other types. Proctoscopy affords the most direct and reliable diagnostic information, since the rectum is the site of primary involvement. Roentgenoscopy determines the extent of the process above the proctoscope, the presence or absence of complications, and offers the only objective evidence of the disease in that five per cent without rectal involvement. Tuberculous colitis usually presents early roentgen findings of combined involvement of the ascending colon, cecum and terminal ileum. It may, however, be confined to the cecum and proximal segments of the ascending colon, and simulate amoebic colitis. Other sources of primary involvement may be sought for differential help. Chest roentgenograms may be of considerable help, because secondary involvement of the intestine with tuberculosis from some distant active focus is quite common. In amoebic ulcerative colitis the cecum and proximal segments of the colon are the sites of earliest and severest involvement with the dependent portions of the colon being frequent secondary sites. The ileum is usually conspicuously free of involvement.

Granulomas are not frequently encountered in the colon above the proctoscopic range. Though of varied etiology, they produce similar roentgen images and are almost identical in gross morphology. The roentgenographic image produced is usually sufficiently distinct to distinguish a granulomatous process from a true neoplasm, but differential signs are difficult where the inflammatory process of perforated carcinoma is encountered.

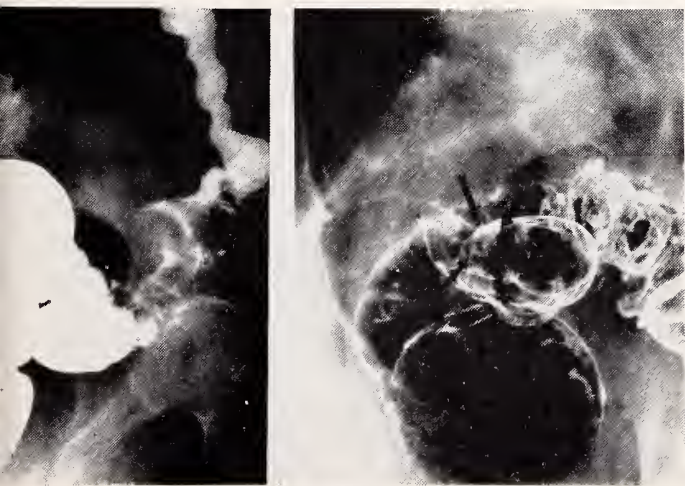


Figure 9-A. Diverticulosis with a polypoid carcinoma involving some area of sigmoid colon.

Figure 9-B. Diverticulosis of sigmoid colon with a small polyp involving same portion of bowel.

Sarcomas are also rare in the colon. Lymphosarcoma is the most prevalent. The deformity has all the roentgen characteristics of a malignant lesion. They may involve longer segments and have a smoother internal relief than carcinoma. Polypoid sarcomas are indistinguishable from other polypoid lesions.

Carcinoma, the most frequent cause of bleeding from the large bowel, in many instances may originate in microscopically benign polypoid lesions designated as polyps. They are intra-luminal, at times difficult to demonstrate, and fail to produce a radiographically demonstrable defect in the colon contours. I still prefer double contrast studies for the demonstration of these lesions. Repeat studies may be necessary to confirm their presence. Fictitious polyps should not be present with the same characteristics on two occasions. These tumors may be simple, scattered, or diffusely involving the mucosa of a segment or the entire colon. Polyposis describes this situation. When this latter condition takes origin on normal mucosa it is said to be primary, as distinguished from secondary polyposis. The latter is considered a regenerative or reparative process of a previous ulcerative condition of the bowel. Both types are important because of their tendency toward malignant transformation.

Carcinoma is certainly the lesion to be suspected as the cause of hemorrhage in the adult where the colon is studied, and a most careful search should be made for it. A filling defect must be demonstrated before a diagnosis of carcinoma can be made and it is defined as a "subtraction" deformity. The annular type, distinguished by the so-called "hook," ulceration is seldom demonstrated and fixation is rare. In comparison, polypoid carcinoma can be best described as a cauliflower like mass which is intraluminal and ulcerates frequently. The characteristic short deformity of carcinoma gives way to a longer, smooth, gradual deformity when associated with perforation. In some instances it is difficult to differentiate from a granulomatous process, however a "hook-like" deformity can usually be visualized on one side of the lesion.

In Conclusion

(1) The role of the roentgenologist in the demonstration of bleeding lesions of the gastro-intestinal tract is one of indispensability if a correct diagnosis is to be achieved.

(2) His responsibility is to not only prove or disprove the presence of the lesion suspected by the referring physician, but to recognize the possibility of the many other pathological processes which may produce this symptom, and to rule out or demonstrate it, as the case may be.

(3) Most of these pathological processes have been briefly discussed and illustrated roentgenographically.

(4) The importance of early examination should be remembered. The cause of bleeding is demonstrated in a higher percentage of patients if examined

during the time of bleeding, particularly in instances of massive hemorrhage.

(5) Regardless of the care in examination, which includes gastroscopy and surgical exploration, there are some patients in whom the pathology cannot be demonstrated. We are therefore dealing with a problem which may challenge us to the utmost without revealing the true answer. One should not despair, since such problems are solved with patience and thorough study.

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ALL MAG MEMBERS

At the 1953 Annual Session of the Medical Association of Georgia, the House of Delegates passed a recommendation referred by Council that the fiscal year be changed from April 1 through March 31 to January 1 through December 31.

To facilitate this change and follow the instructions of the House of Delegates, all 1954 dues should be collected by county society secretaries and mailed to the headquarters office January 1, 1954.

The House of Delegates also set the MAG dues at \$25 for 1954. This means that \$25 should be sent to the headquarters office for state dues along with the \$25 AMA dues for each member.

Names of physicians whose dues are received immediately will be included in the 1953 Roster of MAG members to be published in the January 1954 issue of the *JMAG*.

Titles of Scientific Papers Due

All members desiring to submit titles of scientific papers for presentation at the 104th Annual Session of the Medical Association of Georgia, May 2-5, 1954, at Macon, should submit such titles to the

headquarters office before December 31, 1953.

Communications concerning this matter should be addressed to the Committee on Scientific Work, 875 W. Peachtree St., N.E., Atlanta, Ga.

VAGINAL DISCHARGE

JAMES BOTHWELL TRAYLOR, M.D., Athens

The vagina is normally moist in every female regardless of age, because the cervical and vulvovaginal glands are constantly secreting clear mucus. The quantity of mucus is increased by both sexual stimulation and pregnancy.

For the purpose of emphasis, the causes of vaginal discharge are discussed in the order of their importance with regard to morbidity. The annoying causes commonly responsible for discharge are therefore presented last.

Cancer

In cancer of the cervix, fundus, vulva and vagina, the discharge may be serious, purulent, sanguineous, or any combination thereof. Inspection of the vulva and vagina may disclose an ulceration. A dark field examination is imperative, and if the results are negative, a biopsy should be performed.

From any suspicious area on the cervix a specimen should always be taken. This may be an office procedure. If the discharge comes from the cervical canal, diagnostic dilatation and curettage should be carried out in the hospital.

Syphilis Chancre

A chancre may occur on any part of the genitals and may be confused with cancer or any of the other ulcerative venereal diseases. Recently, I was one of four physicians who saw a patient with cervical chancre. The clinical impression received was that the lesion was carcinoma. After two biopsies giving negative results, we finally made the correct diagnosis of a simple chancre, and the ulcer rapidly healed under penicillin therapy.

Tuberculosis

Tuberculosis also may appear as an ulceration on any part of the genitals and tends to form sinuses. The discharge may be watery or bloody at first and later caseous. In 90 per cent of the cases of this type the lesions are secondary to tuberculous salpingitis. Diagnosis is made by finding acid-fast bacilli or giant cells on histopathologic examination. Treatment when the disease is complicated by tuberculous salpingitis consists of panhysterectomy to remove the focus of infection. In addition, specific antibiotic therapy should be carried out.

Other Venereal Diseases

Chancroid, lymphopathia venereum and granuloma inguinale do not occur as commonly as the three diseases previously described, but they must be consid-

ered in the differential diagnosis of ulcerative lesions of the lower portion of the genital tract. Skin tests with Ducrey antigen and the Frei test are useful in making the diagnosis of chancroid and lymphopathia venereum. Donovan bodies are found in tissue smears taken from lesions of granuloma inguinale. Reports indicate that all of these lesions respond to the newer type of antibiotic.

Before the commoner causes of vaginal discharge and irritation are discussed, it should be emphasized that in the diagnosis of every ulcerative lesion of the genitals one should think of cancer and syphilis first. If the dark field examination, Kahn test and biopsy give negative results, then other lesions should be looked for.

Trichomonas Vaginalis

The most frequent cause of vaginal discharge is *Trichomonas vaginalis*. The discharge may be profuse, requiring the use of napkins, and the constantly moist state of the perineum may cause irritation and maceration of the surrounding tissue. The discharge is usually greater in amount just before and after menstrual period.

The vaginal acidity is changed from the normal of 4.5 to 6.5. The pH is determined with a strip of nitrazine paper.

When trichomonas infection is suspected, the speculum is inserted with no lubricant, and a small amount of the discharge is gathered on an applicator and placed in 1 cc. of normal saline. Examination of a drop of this suspension under the microscope will disclose the flagellated organisms moving in their typical rotary fashion. These organisms are about one and one-half times as large as a leukocyte. The typical discharge is greenish yellow and bubbly. It may occasionally be thick and yellow and easily confused with a gonorrheal vaginitis.

Good therapeutic results have been obtained with hot vinegar douches in conjunction with A V C Cream® and mandelamine®. The patient is instructed to take two hot vinegar douches daily, using ½ cup of vinegar to 2 quarts of hot water. The douche is to be taken lying down with the bag no higher than the knees. Following each douche one applicator full of A V C Cream® is to be inserted. After one week the cream is applied only following the night douche. This therapy is continued for two weeks. At the beginning of treatment the patient is given 100 tablets of mandelamine® to be divided equally with her husband. Both take three tablets three times a day until the tablets are gone. They aid

Read before the Tenth District Medical Society, Elberton, August 1952.

in eradicating the infection from the urethra and its accessory glands. The douches and cream are resumed at the beginning of the first menses and continued for at least three days after the period is over. The same treatment is continued through two more periods, as this is the most likely time for the infection to recur.

Greenblatt¹ reported the use of aureomycin powder with excellent results. Because of the possibility of sensitizing the patient to a valuable antibiotic, it has been my practice not to resort to this drug.

Moniliasis or Yeast Infection

The next most frequent cause of vaginal discharge is moniliasis. The discharge is cottage cheese-like in character, and there is a normal vaginal pH of 4.5. The patients complain of severe pruritus, and excoriations of the tissues are frequently seen. This disease is common in association with diabetes and pregnancy. It is imperative that all gynecologic patients have a urinalysis. The condition also occurs commonly in young females.

The diagnosis is made by fixing a similar preparation to that used for the diagnosis of trichomonas. In the wet smear the finding of mycelial threads verifies the diagnosis. If none are found, the saline suspension may be cultured at room temperature for three days and re-examined. The most satisfactory treatment in my experience is propion gel[®] used twice daily for one week and then once daily thereafter for two weeks. Relief is almost immediate.

Ovulatory Bleeding

At the time of ovulation there is a decrease in estrogen output of the ovary. This is reflected in the endometrium by slight sloughing and spotting and rarely by active bleeding for a day or so. It is often accompanied by pain in one of the lower quadrants. The pain may be severe. The pain does not indicate diseased or cystic ovaries, but merely excessive bleeding from a ruptured follicle. Surgery is not indicated.

The pain and spotting can usually be controlled by the oral administration of 10 mg. of methyl testosterone for 20 days, beginning on the first day of a menstrual cycle. Thyroid extract is helpful in the treatment of those patients with a low basal metabolic rate.

Chronic Cervicitis

Frequently, many small lacerations of the cervix may result from childbirth. Eversion of the cervix follows. If the patient does not take acid douches and if the physician neglects the eversion, chronic infection ensues in the exposed cervical glands. A persistent mucopurulent discharge then occurs. If the proper treatment is not administered, pain is experienced bilaterally in the lower portion of the abdomen and is accompanied by a dragging sensation in the pelvis. The cervix becomes fixed, and there is pain on motion of the cervix. This pain should not be mistaken for tubo-ovarian disease.

The best treatment is preventive, that is, good postpartum care beginning with vinegar douches two weeks after delivery and cauterization of all eversion six weeks postpartum. For mild and moderate cervicitis, treatment should be cauterization of the cervix by the linear streak method followed by hot vinegar douches.

For severe and long-standing cervicitis, it may be necessary to perform a hysterectomy to obtain satisfactory results.

Cervical Polyps

Cervical polyps are one of the most frequent causes of intermenstrual bleeding and postmenopausal spotting. These growths are frequently infected and produce a purulent discharge.

The polyps are easily seen in the cervical canal and may be removed with a tonsil snare or a small curet. All tissue removed should be examined microscopically.

Gonorrhea

In private practice gonorrhea is not encountered as commonly as in the treatment of patients seen in the clinic, but it should always be kept in mind. In this serious infection, the discharge is creamy yellow and thick. Usually it is possible to express pus from Skene's glands. Bartholin's glands may also be involved. The diagnosis is made by finding typical organisms with Gram's stain. In treatment, the drug of choice is penicillin.

Pinworms and Foreign Bodies in the Vagina

When vaginal discharge and vulvovaginitis occur in female children, infestation with pinworms is likely. Diagnosis is established by finding the ova on scotch tape which has been taken from around the anus early in the morning.

When young females exhibit a foul discharge, foreign bodies should always be suspected.

Atrophic Vaginitis

After the menopause, thinning and drying of the vaginal mucosa occur. The tissues lose their ability to resist infection, and nonspecific infection may follow. Local therapy with estrogenic creams has proven helpful.

Summary

Twelve causes for abnormal vaginal discharge are discussed. Of these, cancer and syphilis are the two most serious causes. Every ulcerative lesion should be subjected to biopsy, and if the result is negative, a dark field examination is in order. The two most frequent causes of vaginal discharge observed in private practice are *Trichomonas vaginalis* and moniliasis; methods of diagnosis and treatment are presented. Ovulatory bleeding is discussed. The causes, treatment and prevention of chronic cervicitis are outlined. Prevention is emphasized and should always be the aim of the obstetrician.

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The following new section in the *Journal* is composed of abstracts of current articles by Georgia authors. This additional service of the *Journal* will be presented each month following the scientific section. All abstracts must be in the *Journal* office by the fifteenth of the month following original publication.

ABSTRACTS

Bivings, Lee, 20 Fourth St., N.W., Atlanta. Gamma Globulin Dosage and Measles Control. *J. Pediat.* 43:401-403 (Oct.) 1953.

In previous reports in 1927 it was shown that measles could be modified or prevented by the use of pooled adult serum or plasma. Plasma was also used in the treatment of three cases of post measles encephalitis, two of these recovered promptly and one after a long period of unconsciousness but without sequelae except an occasional convulsion (dosage 500 to 1000 cc.). This report covers 188 cases given gamma globulin. 102 developed modified measles and 86 escaped measles. Of the latter group 21 subsequently had measles from another contact and ten of these were modified cases. An analysis of the results showed that there was a definite relationship between dosage and results. It was further brought out that sibling contacts were much more likely to develop measles and therefore should have higher dosage.

Optimum dosage for modification—

(within five days of contact) siblings .025 to .03cc/lb.
non siblings .015 to .02cc/lb.

For prevention—

(within five days of contact) siblings .075 to .125cc/lb.
non siblings .05 to .07cc/lb.

My findings coincided with those of Karelitz in that a second case of measles rarely occurs. Occasionally one sees a family whose children apparently do not develop complete protection after an attack of measles. No complications were seen in any child with modified measles. It would seem that much gamma globulin is wasted in over dosage where modification is desired. Time of administration is also important.

Cherry, W. B., Ph.D., Davis, Miss Betty R., and Edwards, Phillip R., Ph.D., Communicable Disease Center, Public Health Service, Atlanta. Observations on the Types and Typing of *Salmonella Paratyphi B* Cultures in the U. S. *Am. J. Pub. Health* 43:1280-1286 (Oct.) 1953.

Over 500 cultures of *Salmonella paratyphi B* from man and animals were subjected to complete serological analysis and were classified as to source, state of flagella antigens, and ability to ferment D-tartrate. The human cultures were classified, as far as possible, on the basis of the clinical condition of the individual from whom they were isolated. These cultures were subjected to phage typing using 10 phages distributed by the International Central Reference Laboratory. About 32 per cent of these were untypable. The decreasing frequency of occurrence of the various types was as follows: 3b, 3aI, 1, Beccles, 3a, Jersey, Taunton, Dundee, and B.A.O.R. Type 2 was not found.

Attention is called to the confusion resulting from the use of the term "Vi" to describe the V (five) antigen of *S. paratyphi B*. Evidence is presented to show that the typing phages

for this organism are not specific for strains containing V (five) antigen nor even for *S. paratyphi B*. It is concluded that these phages do not have the high degree of specificity for *S. paratyphi B* which exists between the Vi typing phages of *Salmonella typhi* and their host cells.

Collier, Thomas W. and Betty Anne Ferguson, B.S., M.T., 706 Gloucester St., Brunswick. Airborne Fungus Spores, Brunswick, Georgia Area. Incidence and Variation with Climatic Changes. *Ann. Allergy* 21:480-493 (July-August) 1953.

A historical review and report for the year 1952 of airborne spores in Brunswick. 1,296 colonies were isolated, in four locations; 865 identified including 28 types. Sudden floods of unknown molds of two types appeared. One time 252 colonies of a single type appeared, which could not be identified. The occurrence of each type of identified mold was charted as to frequency and number: *Penicillium* was dominant 26 times with 225 colonies; *alternaria* 15 times with 162 colonies, *oospora* 8 times with 73 colonies, etc. Graphs were given for the monthly variation of the dominant molds and also for the total mold count.

The total mold count was charted against wind velocity, temperature, barometric pressure, and relative humidity. Wind velocity at the time of exposure was the most striking of the atmospheric factors on the mold count. Rainfall seemed to cleanse the atmosphere. The sudden influx of unidentified molds accompanied high winds. Two potato dextrose agar plates adjusted to pH 3.5 were exposed for 7½ minutes. Incubation was at room temperature for five to seven days, then the colonies were transplanted to Sabouraud's Agar slants and cover slip preparations were made. This permitted examination of the specimens as they were growing.

Faraker, Alvan G., Aguilar Celi, Palinestar and Denham, Sam W., Emory University School of Medicine, Atlanta. Dehydrogenase Activity I. In the Ovary. *Obst. and Gynec.* 2:407-413 (Oct.) 1953.

Sites of dehydrogenase activity in ovaries from 27 women were determined by incubating fresh tissue blocks in neotetrazolium with succinate. Deposition of formazan granules indicating dehydrogenase activity occurred as follows: 1. Light reaction in hilum, outlining blood vessels. 2. Light reaction in stroma, varying in intensity with cellularity. 3. Heavy reaction in epithelium of cortical glandular inclusions and in stroma of senescent ovaries. 4. No reaction in ova, but light deposition in epithelium of primordial follicles. 5. Gradual increase in formazan deposition in cell layers of developing follicles. 6. Intense reaction in cells of corpora lutea. 7. No reaction in corpora albicantia. This pattern of dehydrogenase activity correlated with presumed sites of hormone production in the ovary, as well as with more general evidence of cellular proliferation.

Nichols, Pomeroy, Jr., and Manganiello, Louis O. J., Department of Neurological Surgery, Medical College of Georgia, Augusta. Traumatic Arachnoidal Cyst Simulating Acoustic Neuroma. *J. Neurosurg.* 10:538-539 (Sept.) 1953.

A review of the literature on arachnoidal cysts in the posterior fossa reveals 34 cases reported to date. In all of these cases the cysts occupied a posterior position in relation to the cerebellum, 5 of them being midline posterior. The cyst in the present case differs from the rest in being located anteriorly in the cerebellopontine angle. Etiologically, these cysts are known to occur concomitantly with congenital malformations of the hindbrain, are associated with local and distant inflammatory or infectious processes, and occur as a complication of blood in the subarachnoid spaces. Trauma, or indirect, as noted by Thompson, may be an inciting factor.

The case reported is that of an 18 year old colored male, who slowly developed signs of marked increased intracranial pressure from a lesion in the left cerebello pontine angle. Trauma was a definite etiological factor. The lesion, a cyst, was evacuated with complete and permanent recovery. This report adds a case to the literature in which the cyst was in a location not previously described.

Portnoy, Joseph, B.S., M.S., Olansky, Sidney and Edmundson, Walter F., Venereal Disease Research Laboratory, U. S. Public Health Service, P. O. Box 185, Chamblee. Studies of the Treponema Pallidum Immobilization (TPI) Test. III. Studies on Reproducibility, Effect of Treponemal Concentration and Failure to Demonstrate Sensitization in Vivo. *Am. J. Syph., Gonorr. and Ven. Dis.* 37:413-423 (Sept.) 1953.

In experience with the TPI test over a period of several years, certain difficulties have been encountered which reduce the effectiveness of the test procedure and point the need for careful study of factors affecting the immobilization reaction with the objective of developing a testing method with greater reproducibility.

It was found that the use of a medium containing increased concentration of sodium thioglycollate and large amounts of complement serum in the Treponemal Immobilization Test increases the sensitivity of the test and allows a higher percentage of valid protocols by promoting better survival of the treponemes. Experiments bearing on the reproducibility of the TPI test are described. It was noted that changes in the reactivity of individual sera occurred in opposition to changes in the positive control serum. It was found that the concentration of treponemes employed in the test antigen influenced the reactivity of the positive control serum. Smaller concentrations of treponemes gave more sensitive findings than larger concentrations of treponemes. Sensitization of treponemes by antibody in vivo was not observed.

Prati, Harry D., Ph.D. and Karp, Herbert, Communicable Disease Center, Atlanta. Notes on the Rat Lice *Polyplax spinulosa* (Burmeister) and *Hoplopleura oenomydis* Ferris. *J. Parasitol.* 39: 495-504 (Oct.) 1953.

The paper includes descriptions and drawings of the eggs, three nymphal stages, males and females of the spiny rat louse (*Polyplax spinulosa*) and the tropical rat louse (*Hoplopleura oenomydis*). There are maps showing the distribution of these two species in the United States, the only sucking lice commonly collected from domestic rats during the joint Murine Typhus Control Program of the State Health Departments and the Communicable Disease Center of the U. S. Public Health Service during the period 1945-1952.

Hamilton, W. F., Department of Physiology, Medical College of Georgia, Augusta. The Lewis A. Connor Memorial Lecture: The Physiology of the Cardiac Output. *Circulation* 8:527-543 (Oct.) 1953.

The heart pumps blood in order to transport oxygen, nutrients and wastes to and from the organs of the body. Of these functions oxygen transport is the most important; and signs of circulatory failure are usually caused by failure of oxygen transport.

The physiology of cardiac output has a long history beginning with the contributions of Harvey, Hales, Fick, and Zuntz and eventuating in the modern work with the cardiac catheter, and the dye injection and the pulse pressure methods. The evidence from the literature seems to indicate that the cardiac output is physiologically controlled not by the heart, but rather by the peripheral demand for blood. This latter is made manifest by local dilation of arterioles feeding active organs in response to chemical and reflex stimuli. By means of the aortic arch and carotid sinus reflexes the heart is stimulated or inhibited in such a way that it pumps the quantity of blood needed to maintain the arterial pressure at a constant level.

These reflex and also certain purely myocardial mechanisms interfere in the normal animal with the application of the classical dictum that diastolic size governs the output and work of the heart (Starling's law). Reflexes which bring sympathetic influences to bear on the heart, causing it to do more work, also cause it to become smaller. On the other hand, para-sympathetic influences which lessen the heart action cause the organ to become larger. It is only when these reflex mechanisms are aborted as in Starling's experiments, or when, as in heart disease, they have worked at their maximum and have not sufficed—it is only then that the heart falls back on the fundamental mechanism known as Starling's law.

Mandel, Emanuel E., Jones, Florence L., Willis, Myron J., and Cargill, Walter H., Communicable Disease Center, Atlanta, Departments of Pathology, Medicine and Physiology, Emory University, Atlanta, and the Veterans Administration Hospital, Atlanta. Renal Excretion of Creatinine and Inulin in Man. *J. Lab. and Clin. Med.* 42:621-637 (Oct.) 1953.

The object of this study was to assess the reliability of the renal clearance of endogenous creatinine and of inulin as measures of the glomerular filtration rate. The frequent disparity encountered between simultaneously determined creatinine and inulin clearances in 21 subjects with and 13 without impairment of kidney function indicated that the excretion mechanisms of the 2 substances differ even under normal conditions and, especially, in renal disease. Hence, tubular transfer processes must be invoked for creatinine excretion in addition to glomerular filtration, provided that the filtration rate is represented by the inulin clearance. The latter thesis, recently challenged by some British investigators, appears reaffirmed through observations in 14 clearance experiments suggesting independence of the inulin clearance from the plasma inulin concentration.

The creatinine chromogen clearance was normally about 25% lower than the "true" creatinine clearance but approximated the latter in azotemic patients. Within their known limitations, these two clearances can be considered as acceptable clinical substitutes for the inulin clearance only in the absence of renal disease. Their value as indices of over-all renal competency has not been questioned.

Brown, Lester A., 137 Doctors Building, Atlanta. Glomus Jugulare Tumor of the Middle Ear. Clinical Aspects. *The Laryngoscope.* 63:281-292 (April) 1953.

The author states his observations in six biopsy positive cases, and mentions five clinically positive (biopsies not obtained) cases. (The term GLOMUS JUGULARE is applied to an extremely vascular, chromaffin paraganglion tumor found in the middle ear. In 1945, Rosenwasser, of New York City, first described a case. He based his diagnosis on a paragraph of description of the microscopic anatomy as published by Stacy Guild, of Baltimore, in 1941). This tumor arises in the middle ear, possibly not in the same spot every time, it may not proceed lateral to the ear drum, or it may grow out of the external auditory canal. Its progress may be only moderately rapid, or very slow.

Symptoms include: Tinnitus, impaired hearing, facial paralysis, vertigo, hemorrhage, headache, discharge from the

ear; and itching in the ear. Findings on clinical examination include: Mass in ear, positive "pulsation sign" (Brown), facial paralysis, hearing impairment, possible labyrinthine dysfunction, X-ray findings, positive biopsy. Arteriogram has been useless. Treatment: Due to the slowness of growth and the lack of tendency to metastasize (only a small percentage of these have been observed to metastasize), ample time is permitted for study before treatment. In this series of cases, surgical removal appeared to be the best treatment when feasible, surgical removal combined with X-ray therapy was next, but X-ray therapy alone did not help. Results of therapy will necessitate observations over many years.

Baland, Joseph H., Doctors Building, Atlanta. Subdeltoid Bursitis. *Am. Surg.* 19:892-895 (Sept.) 1953.

Subdeltoid bursitis, or tendinitis, is a common condition. Unless correctly diagnosed it is mistaken for many conditions, namely: arthritis, neuralgia, myositis, neuritis and shoulder, arm, hand syndrome. For chronic subdeltoid bursitis and tendinitis conservative measures are best but for acute deltoid calcified subdeltoid bursitis and tendinitis incision and curettage give quickest and most permanent results.

Greenblatt, Robert B., Medical College of Georgia, Augusta. Cortisone in Treatment of the Hirsute Woman. *Am. J. Obst. and Gynec.* 66:p. 700 (Oct.) 1953.

Cortisone was used in treatment of 27 hirsute women, many of whom also complained of amenorrhea and sterility. The urinary 17-ketosteroid excretion was found to be elevated in most of these patients. An arbitrary dose of 50 mg. oral cortisone per day was administered continuously for periods of time varying from 2 to 18 months. Modification of the rate and amount of facial and bodily hair growth took place in some. An increased number of menstrual periods, ovulatory in some instances and anovulatory in others, oc-

curred in many of the patients. Conception occurred in two of the patients who had complained of sterility.

In comparing our results in these cases with our previous experiences in treatment of hirsute amenorrheic women by ovarian resection, it appears that the patients who experienced little benefit following surgery were significantly aided by subsequent cortisone therapy. Conversely, some of the patients who failed to respond to cortisone were benefitted by ovarian resection. If one can draw conclusions from this small series, it might appear that there are different types of cases—those in whom the disorder is primarily ovarian, others in whom it is primarily adrenal, and others in whom there is an imbalance in the pituitary-adrenal-ovarian axis.

Eberhart, Charles, Atlanta, and Hill, Jahn and Brannen, Joseph, Albany. 704 Piedmont Ave., N.E., Atlanta (Eberhart). The Treatment of Urethritis in Women: A New Etiological Concept. *Sau. Med. J.* 46:937-942 (Oct.) 1953.

"Cystitis" is the most common urological complaint encountered in the female. Urethritis is the most common cause of cystitis. The treatment of urethritis is largely an unsolved problem and is directed toward symptoms rather than cure. This approach is dictated by fact that its etiology remains obscure.

The female urethra is divided into anterior and posterior portions, the former being approximately 1 cm. in length. The anterior urethra of all females possess numerous glands which are subject to chronic infection. The presence of this infection, in some unknown manner, causes the bladder to become unusually susceptible to invasion by other more virulent bacteria which produces acute episodes of cystitis.

With this concept in mind, the anterior urethras of thirty-four women who had had recurring episodes of acute cystitis for an average of six years were amputated. Evaluation of results after an average follow-up period of ten months revealed 75 percent to have obtained excellent results, 12 percent were improved, and 13 percent were failures.

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Georgia Baptist Hospital

Piedmont Hospital

St. Joseph's Infirmary

Emory University Hospital

Ponce de Leon Infirmary

Report of

SOUTHEASTERN REGIONAL

Conference on Veterans Medical Care, Atlanta, November 8, 1953

Appearing on the program at the Southeastern Regional Conference on Veterans Medical Care, sponsored by the Committee on Federal Medical Services of the Council on Medical Service, AMA, November 8, at the Academy of Medicine were the following: Louis M. Orr, chairman, Committee on Federal Medical Services; Mr. C. Joseph Stetler, secretary, Council on National Emergency Medical Service, AMA; Ernest B. Howard, Assistant Secretary, AMA; Mr. George Cooley, Associate Secretary, Council on Medical Service, AMA, and Christopher McLoughlin, chairman, MAG Public Relations Committee.

Attending from *Alabama* were Mr. W. A. Dozier Jr., Amos C. Gipson, Howard L. Holley and B. W.

McNease; from *Georgia*, Eustace Allen, C. C. Aven, W. E. Burdine, A. R. Bush, J. W. Chambers, Alfred Colquitt, Mark S. Dougherty, W. G. Elliott, Ralph Fowler, W. P. Harbin, C. W. Henderson, Hartwell Joiner, George P. Kinnard, Christopher McLoughlin, J. C. Norris, Lester M. Petrie, David H. Poer, J. Harry Rogers, Virgil Williams, Neal Yeomans and Mr. M. D. Krueger; from *Florida*, J. L. Bradley, F. H. Bowen, R. B. Chrisman, Frederick K. Herpel, Norval Marr, Alvin L. Mills, Mr. W. Harold Parham, and George M. Stubbs; from *South Carolina*, Thomas R. Gaines, Mr. M. L. Meadors, Bachman S. Smith, L. P. Thackston, and from *Tennessee*, Charles M. Hamilton, A. M. Patterson, and H. H. Shoulders.

Report of

MAG EXECUTIVE COUNCIL

Meeting, Atlanta, November 8, 1953

Attending a meeting of the Executive Committee of Council of the Medical Association of Georgia at 1:30 p.m., Sunday, November 8, 1953, at the Academy of Medicine, were the following members: William P. Harbin, presiding, David Henry Poer and Mark S. Dougherty. Other members of Council present were Neal F. Yeomans, J. W. Chambers, and W. G. Elliott. Also present was Mr. Milton D. Krueger.

The following action was taken:

1. *Approved* presentation of a gift of a \$100 U. S. Savings bond to Mr. Sid Wrightsman Jr. on the occasion of the birth of a son, David Barton Wrightsman, on Nov. 2, 1953.

2. *Recommended* that J. W. Chambers call a meeting of the Audit and Appropriations Committee to consider informal suggestions of Council Executive Committee members.

3. *Accepted* a report from Mr. Krueger which stated that 157 firms have been invited to exhibit at the 1954 Annual Session and to date 27 spaces have been reserved.

4. *Recommended* postponement of a decision on a recommendation by the Insurance Board (that the Association hire a full-time employee to promote the Georgia Plan) until the Audit and Appropriations Committee could further investigate the matter.

The meeting adjourned at 2:15 p.m.

ANNOUNCEMENTS

DECEMBER 7: Cobb County Medical Society will meet at 7:00 p.m. at the Kennestone Hospital, Marietta.

DECEMBER 7: Telfair County Medical Society will meet at 8 p.m. at the Telfair County Hospital, McRae.

DECEMBER 8: Altamaha Medical Society will meet at 8 p.m. at the Appling General Hospital, Baxley.

DECEMBER 8: South Georgia Medical Society will meet at 7:30 p.m. at the Country Club, Valdosta.

DECEMBER 8: Decatur-Seminole Medical Society will meet at Bainbridge or Donaldsonville.

DECEMBER 9: Tattnall County Medical Society will meet at 1 p.m. at the County Court House, Reidsville.

DECEMBER 10: Jefferson County Medical Society will meet at 8 p.m. at the Jefferson Hotel, Louisville.

DECEMBER 11: Randolph-Terrell Medical Society will meet at 8 p.m. at the Patterson Hospital, Cuthbert.

DECEMBER 14: Walton County Medical Society will meet at 7:30 p.m. at the VFW Home, Monroe.

DECEMBER 14: DeKalb County Medical Society will meet at 7:30 p.m. at the DeKalb County Health Building, Decatur.

DECEMBER 15: Spalding County Medical Society will meet at 6:45 p.m. at the Griffin-Spalding County Hospital, Griffin.

DECEMBER 16: Whitfield County Medical Society will meet at 7:30 p.m. at the Hamilton Memorial Hospital, Dalton.

DECEMBER 16: Worth County Medical Society will meet at 8:00 p.m. at Sylvester.

DECEMBER 17: Fulton County Medical Society Annual Meeting.

DECEMBER 17: Richmond County Medical Society will meet at 7:00 p.m. at the Old Medical College, Augusta.

DECEMBER 17: McDuffie County Medical Society will meet at 8 p.m. at the McDuffie County Hospital, Thomason.

DECEMBER 23: Thomas County Medical Society will meet at 6 p.m. at the Archbold Memorial Hospital, Thomasville.

DECEMBER 29: Polk County Medical Society will meet at 7:30 p.m. at the Wayside Inn, Cedartown.

DECEMBER 29: The Walker-Catoosa-Dade Medical Society will meet at 8 p.m. at the Tri-County Hospital, Fort Oglethorpe.

JANUARY 1: Jenkins County Medical Society will meet at 7:30 p.m. at the Burke County Hospital, Waynesboro.

JANUARY 1: Burke County Medical Society will meet at 7:30 p.m. at Waynesboro.

JANUARY 1: Chattooga County Medical Society will meet at 7:30 p.m. at the Chattooga County Hospital, Summerville.

JANUARY 4: Cobb County Medical Society will meet at 7 p.m. at the Kennestone Hospital, Marietta.

JANUARY 4: Telfair County Medical Society will meet at 8 p.m. at the Telfair County Hospital, McRae.

JANUARY 5: Upson County Medical Society will meet at 7:30 p.m. at the Upson County Hospital, Thomaston.

JANUARY 5: Tift County Medical Society will meet at 7:30 p.m. at the Tift County Hospital, Tifton.

JANUARY 5: Bibb County Medical Society will meet at the State Health Department or Pinebrook Inn, Macon.

JANUARY 5: Hall County Medical Society will meet at 7:30 p.m. at the Avon Restaurant at Gainesville.

JANUARY 7: Coffee County Medical Society will meet at 1 p.m. at the Douglas Hospital, Douglas.

JANUARY 7: Fulton County Medical Society will hold its annual banquet at the Academy of Medicine.

JANUARY 7: Ware County Medical Society will meet at 7:30 p.m. at the Ware Hotel, Waycross.

JANUARY 8: Randolph-Terrell Medical Society will meet at 8 p.m. at the Patterson Hospital, Cuthbert.

JANUARY 11: Walton County Medical Society will meet at 7:30 p.m. at the VFW Home, Monroe.

JANUARY 11: The DeKalb County Medical Society will meet at 7:30 p.m. at the DeKalb County Health Building, Decatur.

JANUARY 12: Altamaha Medical Society will meet at 8 p.m. at the Appling General Hospital, Baxley.

JANUARY 12: South Georgia Medical Society will meet at 7:30 p.m. at the Country Club, Valdosta.

SOCIETIES

Fifth District Medical Society met at the Academy of Medicine, Atlanta, November 5 and the following officers were elected: W. S. Dorough, Atlanta, president; B. Russell Burke, Atlanta, vice president; Purcell Roberts, Atlanta, re-elected, secretary-treasurer. Principal speaker was Frederic N. Silverman of Cincinnati, Ohio, who talked on "Urologic Problems in Pediatric X-Ray Diagnosis." William Harbin, Rome, MAG president, also spoke.

Cobb County Medical Society, in a resolution passed at a recent meeting, stressed the right of physicians to serve on the Hospital Authority at Kennestone Hospital. Quoting a statement from the American Hospital Association and the AMA, the resolution emphasized the fact "It is essential that the technical knowledge of doctors be utilized to advise lay-members of the Hospital Authority about hospital technical and professional matters about which only a medical doctor would have the knowledge." The resolution commended the Cobb County Advisory Committee for its unanimous decision in up-

holding the rights of medical doctors to serve, "as can any other Cobb County citizen on the Hospital Authority."

Georgia Medical Society met at 612 Drayton Street, at 8:30 p.m. November 10. Speaker was Julian F. Chisholm Jr., Boston, Mass. who talked on "Retrolental Fibroplasia." At an earlier meeting, members of the Society approved a plan to begin a series of public medical forums in February. The forum plan, as approved by the AMA and the MAG, was outlined to members by Peter L. Scardino, Savannah.

Muscogee County Medical Society held a Ladies Night program October 29 at the Country Club, Columbus. Special guests for the evening were William Harbin, MAG president, and Mrs. Harbin. William Cook, Columbus, was program chairman for the evening and C. W. Henderson, Columbus, presided.

Ware County Medical Society met November 5 at Waycross. Stewart Flanagan, professor of plastic surgery at the Medical College of Georgia, Augusta, presented a film on plastic surgery. Members of the Society appointed a committee to make plans for a medical forum to be held in Waycross. Members of the committee include H. Ansley Seaman, W. L. Pomeroy, W. M. McGoogan, Neal Yeomans, Arthur M. Knight Jr. and Harold W. Muecke.

PERSONALS

Members of the Gordon County Medical Society recently announced an emergency call system whereby one doctor will be "on call" each night to take care of emergency cases reported to the new Gordon County Hospital. Members of the Society are M. A. Acree, J. E. Billings, W. D. Hall, L. R. Lang, Bill Purcell, C. K. Richards, Byron Steele and R. D. Walter.

Oliver Arteaga, Atlanta, was recently certified by the American Board of Ophthalmology.

C. C. Aven, Atlanta, spoke recently at the annual press conference for high school editors at Atlanta. He stressed the need for hospital beds for tuberculosis patients in the Atlanta area.

R. V. Brandon, McDonough, has installed a car telephone for use in emergency cases when he is out of his office. The telephone is connected to the Atlanta switchboard and connection can be made by calling the long distance operator in McDonough.

Joseph H. Brannen, formerly of Albany, has

opened offices at the Little-Griffin Hospital in Valdosta for the practice of urology.

Ellison R. Cook III, Savannah, formerly of Newnan, has been named president-elect of the Georgia Heart Association.

A. J. Crumbley, Atlanta, formerly chief resident in surgery at Piedmont Hospital, announces the opening of his office at 564 Lee Street, S.W., for the practice of general surgery.

Dr. and Mrs. Hal M. Davison, Atlanta, recently entertained members of the board and publicity chairman of Active Voters at their home, 288 Habersham Rd., N.W. Dr. Davison is president of Active Voters.

Albert Deal and his wife, Helen Deal, both physicians in Statesboro, attended a meeting of the State Board of Medical Examiners in Atlanta recently.

Guy J. Dillard, Columbus, was guest speaker at the meeting of the Third District Division, Practical Nurses Association of Georgia, Columbus. He talked on "The Practical Nurse and Her Opportunity for Service."

Mark S. Dougherty, Jr., C. Dixon Fowler, both of Atlanta, and Robert L. Bennett, Warm Springs, participated in the Third Annual Meeting of the Georgia Society for Crippled Children, Inc., October 23 at the Academy of Medicine, Atlanta.

William H. Good Jr., surgeon at the Toccoa Clinic and Hospital, addressed the Pilot Club of Toccoa at the Albemarle Hotel recently. He spoke on "Citizenship—its benefits, duties and responsibilities."

William F. Hamilton Sr., *Edgar R. Pund* and *Harry B. O'Rear*, Medical College of Georgia, Augusta, attended a meeting of the Association of American Medical Colleges at Atlantic City.

William G. Hamm, Atlanta, was recently named president-elect of the American Society of Plastic and Reconstructive Surgery at the group's four-day meeting in San Diego, Calif.

The Toccoa Clinic Medical Associates announce the association of *Samuel H. Hay* with the group for the practice of internal medicine.

Henry S. Jennings Jr., Atlanta, recently left the Emory University Clinic and opened offices at 608 East Broad St., Gainesville for the practice of internal medicine, effective December 1.

J. R. McCain and *W. M. Lester*, both of Atlanta, collaborated on an article, "Prolonged Labor," appearing in the October 24 issue of the Journal of the American Medical Association.

William Cecil McGarity, Atlanta, has been inducted as a fellow in the American College of Surgeons.

Harold W. Muecke, Waycross, presided over the section on pediatrics at the recent Southern Medical Association meeting in Atlanta.

J. C. Patterson, Cuthbert, recently addressed the Cuthbert Rotary Club at a luncheon meeting held at Andrew College.

T. A. Peterson, Savannah, addressed the Savannah Rotary Club recently. He stressed the need for a rehabilitation center in the city.

Macon physicians taking part in the local Community Chest drive include *A. M. Phillips*, chairman, and *J. Benjamin Stewart*, *W. W. Baxley*, *Thomas Harrold*, *W. D. Hazellhurst*, *F. M. Houser*, *E. C.*

McMillan, *William W. Orr*, *Sam Patton*, *Leon Porch*, *R. M. Reifler*, *Raymond Suarez* and *Charles Wasden*.

B. F. Riley Jr., Thomson, who was ill for several months, has resumed his practice at his home 314 Whiteoak Street. He expects to be able to return to his office in the Martin Theater Building in the near future.

Robert E. Roberts, Atlanta, announces the opening of his office at 117½ Lee Street, S.W., Atlanta, for the practice of internal medicine.

A. A. Rogers, Commerce, has been re-elected chairman of the board of deacons of the First Baptist Church of Commerce.

Oscar Leslie Rogers, Sandersville, has retired as Washington County Health Commissioner after 23 years of service. He has been practicing medicine in Washington County since 1898.

Hahira civic organizations recently honored *J. R. Smith*, Hahira, who has been practicing medicine in the community for 52 years.

O. R. Styles, Cedartown, has announced his association with *Don W. Schmidt* in the practice of general medicine and surgery.

Benjamin C. Wills, Savannah, addressed the medical staff of the Veterans Administration Hospital, Dublin, recently. His topic was "Psychosomatic problems in a general hospital."

Bernard P. Wolff, Atlanta, presented two lectures at the Forest Hills Division, Veterans Administration Hospital, Augusta. His topic was "Phthisiogenesis."

R. Hugh Wood, Dean, Emory University School of Medicine, presented a report on present status of VA-medical school relations at a meeting of the Association of American Medical Colleges at Atlantic City.

Edgar Woody Jr., Atlanta, announces the removal of his office to 1211 West Peachtree St., N.E., for the practice of internal medicine.

DEATHS

BAXTER, J. H., 74, Ashburn, who was awarded a life membership in the Medical Association of Georgia at the 1953 Annual Session, died October 13 at his home. A well known Turner County physician, Dr. Baxter was educated at Emory University and George Washington University. He was a member of the Ashburn Methodist Church, the Masonic Order, the Shrine, and Kappa Alpha and Phi Chi Fraternities.

BINION: *Richard*, 62, Milledgeville, died October 21 at his home. A native of Sparta, Dr. Binion had practiced medicine in Milledgeville since 1918. He received his medical education at Emory University and the University of Maryland. He was a fellow of the American College of Surgeons and a member of the American Psychiatric Association, the Southern Medical Association and the Baldwin Medical Society.

BOLAND: *Frank K. Sr.*, 78, Atlanta. See *Editorial* for biographical sketch.

HENDRY: *Wayland M. Jr.*, 37, Washington, formerly of Atlanta, died November 16 at his parents' home in Washington after a long illness. Dr. Hendry attended Emory at Oxford, the University of Georgia and the Medical College of Georgia. During World War II he served in Europe as a battalion surgeon with the 44th Infantry Division, and later as a general surgeon in an Army-Navy Hospital. From 1946 to 1949 he was a resident surgeon-physician at Georgia

Baptist Hospital, Atlanta.

STAMPA: *Samuel*, 67, Atlanta, died November 4 in an Atlanta hospital after a brief illness. A specialist in industrial surgery and a member of the visiting staff of Georgia Baptist Hospital, he was a graduate of the Atlanta College of Physicians and Surgeons. He was a member of Fulton Lodge No. 216, F. & A. M. and of Ahavath Achim Congregation.

What is the Physician's Responsibility?

Rural or Community Health Councils have headed the list of requests coming to the Better Health Council of Georgia this fall. At a recent meeting in one of the rural counties, citizens from the community discussed health legislation, scholarships for teachers of Mentally Deficient Children in Georgia, and many problems concerning state and community health. A question was asked in all sincerity and with the desire of cooperation between the doctor and the community—what is the physician's responsibility in the community?

In an adjoining county, another request has come to the Council to assist in the final organizational plan of a rural health council. In going into the county with such a request, it is always necessary to point out certain fundamental principles for or-

ganizing a health council: 1) good leadership from a citizen in the community; 2) is the organization of the local health council timely for the community; 3) surveying the needs in community health to be followed by the selection of *one* project that is available and which can be accomplished.

There has been a recent request to assist with plans for a new health council in a suburban area of Greater Atlanta. Projects and leadership will be discussed with the Council members after a survey of health needs has been made.

With the full cooperation of the Rural Health Committee of the Medical Association of Georgia, the Better Health Council can go forward with greater confidence in its guidance of local health councils.

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